Medicaid Program Evaluation

Working Paper

MPE 9.1 June 1986

**Medicaid Program Evaluation:
A Synthesis of Interim
Findings**

Department of Health and Human Services
Health Care Financing Administration
Office of Research and Demonstrations

REPORTS
RA
412
.4
M43689
no.9.1

This Working Paper is considered an internal document and is not intended to be an official publication. The material presented has not been cleared for publication and should not be quoted without permission of the author(s). The views expressed are solely those of the author(s) and do not necessarily represent the position of or an endorsement by the Health Care Financing Administration.

RA
412.4
.M43689
no.9.1

Department of Health and Human Services
Health Care Financing Administration
Office of Research and Demonstrations

Medicaid Program Evaluation

Working Paper

MPE 9.1 June 1986

Medicaid Program Evaluation: A Synthesis of Interim Findings

Project Officer: Gerald Adler
Health Care Financing Administration

Editors: Judith Feder, Georgetown University
John Holahan, The Urban Institute

Contributors: Lawrence Bartlett, Larry Beyna, James Bell, Christine Brudevold, Brian Burwell, Joel Cohen, Jerry Cromwell, Claudia Hanson, Ian Hill, Gail Jones, Michael Koetting, Holly Korda, Stephen Long, Sally McCue, Edward Neuschler, Lois Olinger, Helen Rosenthal, Russell Settle, Bruce Steinhardt, and John Trutko

This Working Paper was developed under HCFA Contract No. 500-83-0058 with James Bell and Associates, Inc., by The Urban Institute, 2100 M Street, N.W., Washington, D.C. 20037, (202) 857-8666.

TABLE OF CONTENTS

	Page
Preface	i
EXECUTIVE SUMMARY	1
I. MEDICAID SPENDING AND ENROLLMENT AFTER 1981	10
Overview of Change	10
Factors Explaining Lower Rates of Spending Increase in 1982	20
II. STATE REACTIONS TO CHANGES IN FEDERAL POLICY	32
Medicaid in the Budget Process	32
State Policy Choices	35
III. ELIGIBILITY	40
IV. HOSPITAL REIMBURSEMENT	51
V. FREEDOM OF CHOICE	63
Delivery System Changes	63
Lock-In Program	76
Volume Purchasing	80
VI. HOME AND COMMUNITY-BASED CARE	85
VII. FINANCIAL INCENTIVES FOR FAMILY CARE	99
MEDICAID PROGRAM EVALUATION WORKING PAPERS	114

LIST OF TABLES

Table		Page
1	Percentage Changes in State Medicaid Expenditures, by State	11
2	Medicaid Recipients and Expenditures, by Eligibility Group, 1979-1982	14
3	Average Annual Increases - Medicaid Recipients and Expenditures by Service, United States, 1979-1982	18
4	Means and Standard Deviations of Variables	21
5	Determinants of State Medicaid Spending - Regression Results: Total, Acute Care and Long-Term Care Expenditures	22
6	Impact of Federal Matching Contribution Reductions, by State, 1982	26
7	Impact of Federal Matching Contribution Reductions, by State, 1983	28
8	Average Real Changes in Spending, by Function	34
9	Medicaid Inpatient Hospital Reimbursement Method, by State	53
10	Average Annual Growth in Medicaid Inpatient Hospital Expenditures for Pre- and Post-OBRA Periods, by Reimbursement System	55
11	Summary of Programs for Which Waivers Have Been Requested Under Section 1915(b)	65
12	State PCCM Characteristics (Implemented Programs)	69
13	Medicaid Recipient Lock-In Programs	78
14	Estimated Savings Attributed to State Medicaid Lock-In Programs (1982), Based on Comparisons of Expenditures Made Before and During the Restriction Period	81
15	Known State Medicaid Volume Purchasing Programs	83
16	Section 2176 Waiver Programs Approved as of November 1, 1984 ...	88
17	Waiver Programs with Approved Services, by Target Population ...	92
18	Total Number of Persons Served through June 1, 1984, by Target Group and Waiver Program	93
19	Projected Waiver Program Impact on LTC Expenditures, by Level of Care and Waiver Year	95

LIST OF FIGURES

Figure		Page
1	Medicaid Expenditures, Actual and Adjusted, 1974-83	12
2	Recipients by Eligibility Category, 1979-81 vs. 1981-82	15
3	Medicaid Enrollees as a Percentage of Persons in Poverty	17
4	Expenditures by Service Type, 1979-81 vs. 1981-82	19
5	Inpatient Hospital Expenditure Change, by Reimbursement Method	56
6	California Savings - Average Monthly Payments	60
7	Approved Waivers, August 31, 1984	68
8	Recipient Participation in Private Physician PCCMs	71
9	States with Section 2176 Waiver Programs for the Aged and/or Disabled	89
10	States with Section 2176 Waiver Programs for the Developmentally Disabled and/or Chronically Mentally Ill	90
11	Sources of Long Term Care for Elderly	100
12	State Financial Incentive Programs	106

PREFACE

The Medicaid program, which finances health care for over 20 million needy Americans, has undergone major changes since 1981. Beginning with the Omnibus Budget Reconciliation Act of 1981 (OBRA), Congress gave the states much more flexibility to change basic parameters of the program, including which groups of people are served, what services are provided, how doctors, hospitals, and nursing homes are paid, and how care can be organized in innovative ways.

The Medicaid Program Evaluation addresses the implementation and impact of selected changes in the Medicaid program to provide knowledge for policy assessment and future legislative change. It is focused on selected issues and policy questions raised by recent legislation.

- Federal Financial Participation
- Inpatient Hospital Reimbursement
- Eligibility
- Case Management
- Home and Community-Based Waiver Program
- Cost-Sharing
- Financial Incentives for Family Care
- Medicare DRG Effects on Medicaid
- Synthesis

Together these studies are intended to describe how recent changes have been implemented, and analyze what their effects have been for program services and costs.

This paper provides an overview of program changes and examines the immediate change seen in the post-OBRA period in expenditure trends, types of services, and types of recipients. It then analyzes the reasons for observed changes, particularly the relative influence of policies and economic conditions in bringing about slowed expenditures.

Gerald Adler
Project Officer
HCFA Office of Research

EXECUTIVE SUMMARY

The 1980s brought major changes to the Federal-State Medicaid program. Important budget legislation, severe economic recession, and an upsurge in health cost containment activity by government and the private sector significantly affected Medicaid policies, Medicaid spending, and services to the nation`s poor.

On September 30, 1983, the Office of Research and Demonstrations of the Health Care Financing Administration began a three-year evaluation to assess changes occurring in the Medicaid program. The goal is to describe how Medicaid has changed since 1981; to analyze the causes and consequences of those changes; to identify the policy instruments used to bring changes about; and to derive lessons for future federal Medicaid policy. This report synthesizes the findings that emerged in the project`s first year.

Planning for the Medicaid Program Evaluation, as the study is called, started after passage of the Omnibus Budget Reconciliation Act (OBRA) of 1981, legislation initiating the most substantial Medicaid reforms since the early 1970s. OBRA initiated three broad types of change: (1) reductions in federal financial participation--the federal "match" on state Medicaid spending; (2) changes in eligibility for welfare benefits (AFDC), to which Medicaid eligibility is tied; and (3) greater flexibility in states´ choice of Medicaid policies than the statute previously allowed.

These legislative changes derived from a general interest in slowing Medicaid cost increases and from two more specific sources--the federal government`s efforts to reduce federal spending and state governors´ interest in greater freedom in program design.

With costs rising 15 percent annually throughout the 1970´s, Medicaid aroused budgetary concern. The program was therefore an attractive target for efforts to reduce the federal budget in 1981. To limit federal obligations and encourage states to control Medicaid spending, the Reagan administration´s 1982 budget proposed to set a "cap" on annual rates of growth in federal contributions to Medicaid financing. Alongside the cap, the administration proposed to give the states more flexibility in program design to achieve efficiency and spending control.

Responding to strong opposition from state governors, the Congress rejected the proposed cap on federal spending. Instead, they took the more modest step of reducing slightly (3, 4, and 4.5 percent) the share of Medicaid spending the federal government would pay from 1982 through 1984, if states exceeded specified expenditure targets. Congress also reduced federal (and state) Medicaid liabilities indirectly by setting limits on welfare eligibility levels to which Medicaid is tied.

At the same time, Congress awarded the states greater flexibility in program design, an administration proposal that the governors warmly endorsed. Although OBRA fell short of the administration´s and the governors` goals, the new law did eliminate several restrictions on program design. Some of the new freedom allowed states to reduce eligibility or service in ways previously

prohibited. Along with these cuts were measures that would promote innovations in service delivery and more efficient use of Medicaid dollars.

OBRA's passage in 1981 was a major but not the only stimulus for changes in the Medicaid program in the early 1980s. In late 1980, the nation began to slide into the worst recession since the Depression of the 1930s. As unemployment rates rose dramatically, state revenues fell significantly short of spending commitments. The pressure to cut Medicaid, one of the fastest growing programs in most states' budgets, was enormous and quite independent of federal legislation.

In combination with the recession, however, OBRA laid the groundwork for some new approaches to Medicaid policy, in the short and long term. In the short term, OBRA both added pressure on the states to control spending (with reductions in federal matching rates if target growth rates were exceeded) and gave the states some new policy tools (mandated eligibility limits and optional changes in policy design). How did these actions affect state behavior? More specifically, did the options OBRA offered lead states to control spending more or differently than they otherwise would have done?

Over the long term, OBRA may have an even greater impact on state policy. Analysts have observed that historically most states' efforts to contain Medicaid costs have been limited to periods of fiscal crisis and characterized by a barrage of benefit and service cuts.* By promoting greater control over service use and innovations in health care delivery, OBRA aimed to give states the opportunity for more systematic and sustained mechanisms for containing costs. State initiatives in these areas may be reinforced (by example or practical overlap) by others' cost containment activities--the development of PPOs in the private sector, or Medicare's adoption of a hospital prospective payment system. Over the long term, then, how are states altering their Medicaid programs? Are they serving people more efficiently?

The Medicaid Program Evaluation aims to answer these questions as part of a broad analysis of changes in Medicaid since 1981. The evaluation involves a number of diverse studies conducted between October 1, 1983 and September 30, 1986, to address the following Medicaid policy areas: eligibility, freedom of choice, cost sharing, federal financial participation, hospital payment, home and community care waivers, and financial incentives for family care. The first four areas of evaluation tasks and this synthesis are being conducted under contract with James Bell and Associates, with subcontractors Syracuse University, The Urban Institute, National Governors' Association, and Georgetown University. Abt Associates, with subcontractors Health Economics Research and Compass Associates, is analyzing hospital payment changes. La Jolla Management Corporation, with subcontractor SysteMetrics, is studying home and community care and incentives for family care.

---

*Randall R. Bovbjerg and John Holahan, Medicaid in the Reagan Era: Federal Policy and State Choices, Washington, D.C.: The Urban Institute Press, 1982.

This report represents a synthesis of these studies' interim findings. Since it summarizes work done in the first year of the evaluation, the report focuses heavily on OBRA's role relative to other factors in producing changes in the Medicaid program during 1982-1983. In the next two years, the evaluation will focus less on OBRA's impact and more on broad changes in the Medicaid program--their causes and consequences. In addition, OBRA-induced innovations in health care financing or delivery that were neither fully implemented nor evaluable in 1982-1983 will be more thoroughly examined.

This report attempts to summarize our knowledge of Medicaid experience through 1983, proceeding through a number of steps. The first step (Chapter I) is to identify changes in various aspects of the Medicaid program after 1981. What changes occurred in Medicaid spending following OBRA's enactment? What population groups were most affected? What was OBRA's impact, distinct from the recession? Then in Chapter II, we ask, how did these changes occur? How did state governments, which actually put Medicaid policies into effect, respond to OBRA, the recession and other factors in making their Medicaid policies? Did they use different tools to control costs than they otherwise would have? How did they use their new flexibility?

The remainder of the report addresses specific policies and their effects, focusing on the policy areas in which OBRA made significant changes in states' authority. Chapter III examines how eligibility policy changed after OBRA, identifying states' responses to mandated and optional authority and analyzing the consequences of policy change for program spending and the poverty population. Hospital payment change is the subject of Chapter IV. That chapter describes how states have changed their payment practices, examines the impact new forms of hospital payment have had on Medicaid spending to date, and assesses California's so-far unique experience with hospital contracting.

Chapter V describes how states have responded to new authority to depart from freedom of choice requirements and to impose cost sharing. This description indicates how interested states are in financing and delivery changes and describe their approach to program implemention.

Chapters VI and VII describe state initiatives in long-term care, stimulated by new authorities granted by OBRA. Analyses focus on two distinct areas: home- and community-based care and family contributions to financing long-term care.

In the first year, studies revealed the following about the Medicaid program:

Overview of Medicaid Cost Containment 1981-1983

What happened to Medicaid spending?

- Between 1981 and 1982, the rate of increase in Medicaid spending fell dramatically. Spending dropped 0.4 percent in real terms, in sharp contrast to annual increases of 7.4 percent for 1979-1981.

- About a third of the decline resulted from reductions in eligibility, and about two-thirds from reductions in spending increases per eligible.

- The ratio of Medicaid enrollees to the poverty population fell 11.2 percent between 1981 and 1982. In 1982, the ratio was 45 percent, down from 51 percent the year before.

- Children experienced the greatest declines in Medicaid eligibility and in spending per eligible.

- Spending reductions for children reflect this population's greater use of services that experienced the greatest cutbacks in 1981-1982 (physician care, prescription drugs and dental care).

How were spending reductions achieved?

- New forms of hospital payment that OBRA encouraged may have contributed to 1981-1982 cost containment but other structural changes OBRA induced (like primary care case management, or home and community-based care) started too late and were too small to have affected spending in that period.

- States that effectively contained spending per eligible between 1981 and 1982 relied primarily on cost containment tools that existed prior to OBRA, rather than newly authorized approaches.

- Some of OBRA's new authorities were used by most states —e.g. community and home-based care waivers; elimination of coverage for 18-21 year olds. Other new authorities have hardly been used—e.g. volume purchasing of laboratory services; elimination of medically needy categories and services; elimination of Medicaid coverage for first-time pregnant women.

What caused spending reductions?

- It appears that the recession was the primary factor motivating expenditure reductions in 1981-1982. As the economy improved in 1982-1983, Medicaid spending increased by 5 percent after deflating by the Consumer Price Index—a level nearly comparable to pre-OBRA rates of increase.

- OBRA's reductions in the federal matching rate had a weaker effect than the recession on Medicaid spending. Incentives to keep costs below target levels appeared too small to have had any independent impact on state spending.

- Although the recession and the matching rate reductions are the primary dampening forces, OBRA-authorized changes in state policy may have kept Medicaid spending on acute care below levels they would otherwise have reached.

- Real increases in Medicaid spending in 1982-1983 raise questions about future rates of increase in Medicaid spending. How OBRA-induced innovations, economic conditions, demographics, state policy choices, and other factors will affect Medicaid over the 1980s remains uncertain.

Eligibility

- Between 1981 and 1982, numbers of Medicaid enrollees declined almost 5 percent--5.2 percent for enrollees receiving cash assistance; 1.4 percent for enrollees not receiving cash assistance.

- As expected, OBRA's eligibility changes fell most heavily on working AFDC recipients. Their elimination from the Medicaid rolls is apparent from the 12 percent decline in income levels among the working Medicaid population between 1981 and 1982--a decline 10 points greater than that experienced by a similar non-eligible population, affected by the recession.

- An estimated 55 percent of the persons who lost Medicaid eligibility due to OBRA obtained private health insurance. These individuals' use of health services was not affected by the loss of Medicaid benefits.

- An estimated 45 percent of the population that lost Medicaid eligibility due to OBRA did not obtain private health insurance. Based on service use by a similar population without insurance coverage, it is estimated that, over time, use of physician services among the newly ineligibles would decline 38 percent; use of inpatient hospital services would decline 71 percent; purchase of prescription drugs would decline 39 percent; and use of dental services would decline 61 percent.

Hospital Reimbursement

- As of October 1984, 33 states had prospective payment systems, more than twice the number (14) in 1981 before OBRA's enactment. Six of the prospective systems were per-case methods similar to Medicare's DRG approach. Only eleven states used retrospective cost reimbursement without some ceilings on payment.

- Annual rates of increase in Medicaid hospital spending for the nation were slightly lower in 1981-1983 (10%) than they had been in 1979-1981 (12.2%). The lower rate of increase reflects declines in recipients--seemingly a function of changes in eligibility, utilization controls, and rate reductions that may have reduced hospitals' admissions of Medicaid patients.

- Although all states experienced lower rates of increase in hospital spending after OBRA than before, the largest drop in rate of increase and the lowest post-OBRA rate of increase occurred in states with prospective payment systems.

- States whose alternative hospital systems pre-dated OBRA had much lower rates of increase in hospital spending in 1981-1983 than did states maintaining retrospective cost-based reimbursement and states with newly adopted alternatives.

- California's contracting system for hospital payment--the most dramatic post-OBRA innovation in hospital payment--reduced Medicaid per diem rates by about 16 percent. Utilization controls prevented offsetting volume increases. Total savings are estimated at $140 million for 1983-1984.

- Contracting in California served to get hospitals already serving Medicaid patients to do so at lower rates, not to shift Medicaid patients from high cost to low cost institutions.

Freedom of Choice

- As of August, 1984, 25 states had submitted requests for 62 freedom of choice waiver programs. Twenty-two waivers have been granted for primary care case management programs and thirteen have been implemented.

- All but two primary care case management programs operate on a less than statewide basis. All approved programs are open to AFDC recipients; some cover aged, blind and disabled individuals meeting SSI-related eligibility requirements as well. Most programs exclude joint Medicare-Medicaid beneficiaries, individuals residing in nursing homes, and the medically needy.

- The largest program in terms of population covered is the Michigan Primary Physician Sponsor Plan. The program had 53,940 recipients and 1,270 physicians by September 1984. There is no evidence yet on the programs impacts on state expenditures.

- Nine states established recipient lock-in programs following OBRA, while twenty-eight had programs before its enactment. The size of the locked-in population doubled over a two-year period, exceeding 64,000 by mid-1984. This is less than .4 percent of all Medicaid enrollees.

Home and Community Based Waivers

- As of November 1, 1984, 67 requests for Section 2176 waivers from 42 states and the District of Columbia had been approved; an additional 21 requests were in process at the time.

- As of June 1, 1984, more than 53,000 persons had been provided home and community based services under the Section 2176 waiver authority. This amounts to about 3.5% of the annual number of nursing home recipients on Medicaid and is close to the projected total caseload across all implemented waiver programs. Five programs accounted for 60% of total enrollment as of this date.

- Mentally retarded persons are a particularly important target group. While recipients of ICF-MR care comprise about 10% of the total Medicaid nursing home population, persons diverted or deinstitutionalized from ICF-MR level of care comprise about one-third of the current waiver program caseload.

- In waiver applications approved as of June 1, 1984, states estimated that their Section 2176 waiver programs would reduce their combined nursing home populations by approximately 54,868 recipients in the first year, or 5.2% of their nursing home recipient population in the levels of care served under the waiver.

- In waiver applications, states projected first year costs for waiver services of $302.5 million, reductions in nursing home expenditures of $705.9 million, and total net savings of $403.4 million. Over 40 percent of all net savings were projected to result from reduced expenditures for ICF-MR care.

- Due to delays in program implementation and lags in the submission of annual reports on waiver program expenditures, data on the actual cost impacts of the program are extremely sketchy at this date. Through October of 1984, only 16 state Annual Reports on the waiver (HCFA 371s) had been accepted by HCFA. Comparisons between HCFA 371s and waiver formula projections showed that actual waiver program experience often differed substantially from estimates made in state waiver

applications. Using waiver formulas as the basis for assessing program savings, analysis of the HCFA 371s showed that waiver programs serving the developmentally disabled were more likely to achieve significant reductions in Medicaid long-term care expenditures (between 5% and 20%), whereas waiver programs serving the aged and disabled were more likely to show marginal savings or a budget neutral effect. Since only three reports on total Medicaid expenditures for waiver recipients (HCFA 372s) had been accepted by HCFA as of this date, the analysis did not take into account potential impacts on total Medicaid costs.

Financial Incentives for Family Care

- No evidence exists that the level of care provided by informal caregivers has declined in response to the growth in public expenditures for long-term care.

- Several Medicaid and SSI eligibility policies may affect family members' willingness to care for elderly relatives. These policies include SSI deeming policies, transfer of asset policies, lien laws, reduction in SSI benefit for shared living arrangements, and SSI states supplementation rules.

- Two new Medicaid options (in addition to home and community-based care waivers) promote in-home care. Eight states have adopted TEFRA's Section 134 option, which covers disabled children at home if they would be eligible for SSI in a medical institution; and 19 statess have received Katie Beckett waivers, which allows individuals to be excepted from eligibility restrictions on a case-by-case basis.

- Experience with states programs that pay family members to provide care reveal several possible advantages--flexibility, higher quality care, lower cost per service, and positive reinforcement of family care. Experience also reveals several possible risks--payment for care already provided free of charge, inequity, abuse of elderly relatives, and interference with existing informal care arrangments.

- In response to a 1983 HCFA transmittal, one state, Idaho, instituted a requirement that adult children contribute to nursing home costs of elderly relatives. The program was terminated six months after implementation when the states attorney general rendered an opinion that the program was not in compliance with the HCFA transmittal. The cost savings of family

responsibility programs are difficult to project and political opposition to their enactment remains strong.

- Tax provisions may affect the elderly's ability to remain at home or to obtain family care. Relevant federal tax incentives now in existence include: exclusion of capital gains tax on home sales for the elderly; tax credit for the elderly; additional exemption for the elderly; exemption for dependents; and credit for child and dependent care expenses.

- Four states (Idaho, Oregon, Arizona, and Iowa) have also adopted tax incentives targeted to elderly persons in need of long-term care or to their caregivers.

I. MEDICAID SPENDING AND ENROLLMENT AFTER 1981

Overview of Change

Before discussing Medicaid policies in detail, it is essential to have a clear picture of changes for the program as a whole. This chapter offers that picture. For 1981 and 1982, the chapter asks: How did Medicaid spending change in the face of recession and legislative change? What groups of Medicaid recipients were most affected by spending reductions? How has Medicaid's coverage of the poverty population changed? How did Medicaid spending vary across services?

Following this general analysis, the causes of spending reductions are examined. How much did federal policy change, as distinct from the recession, contribute to spending reductions? And, given those findings, what is likely to happen to Medicaid spending as the economy improves?

Unless otherwise noted, this chapter summarizes the findings presented in John Holahan, "The Effects of the 1981 Omnibus Budget Reconciliation Act on Medicaid," MPE Working Paper 7.3.

What happened to Medicaid spending in the recession and federal cuts?

Between 1981 and 1982, Medicaid spending fell in real terms. (See Table 1.) The 6.4 percent increase in nominal spending did not keep pace with a general inflation rate of 6.8 percent, producing a reduction in real spending of 0.4 percent.

This drop contrasted sharply with the steady rate of increase in Medicaid spending since 1974 (see Figure 1) and the very high increases of the two preceding years. From 1979 to 1981, Medicaid spending increased in nominal terms 17.3 percent per year, significantly faster than the inflation rate of 9.4 percent per year. In real terms, Medicaid spending increased 7.4 percent per year between 1979 and 1981.

The national spending decline in 1981 resulted from lower rates of spending across almost all states. Although there was considerable variation in Medicaid growth rates across states, all but four jurisdictions (Connecticut, District of Columbia, Louisiana, and Utah) had lower nominal growth rates between 1981 and 1982 than they had averaged between 1979 and 1981. Twenty-six states' spending declined in real terms, and ten states actually spent less in nominal dollars in 1982 than they had spent in 1981.

Expenditures changes are the product of two distinct events--changes in numbers of Medicaid recipients and changes in expenditures per recipient.

How did changes in numbers of recipients and expenditures per recipient, respectively, affect total spending?

Both components of spending declined in 1982, but reductions in spending per recipient accounted for a larger share of spending reductions (65 percent) than did the decline in recipients (35 percent).

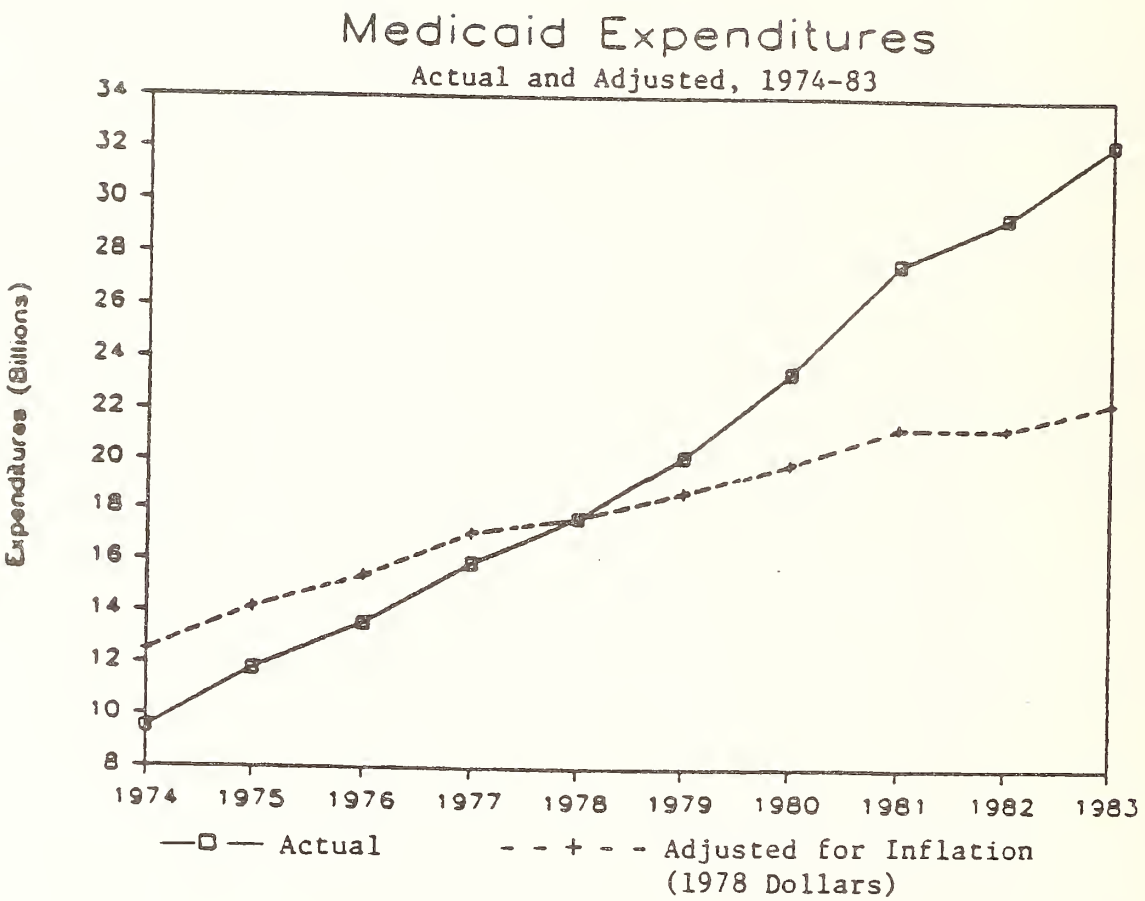
Table 1

Percentage Changes in State Medicaid Expenditures, by State

	State	1979 Expenditures (in millions) (1)	Annual % Change 1979-1981 Nominal (2)	Annual % Change 1979-1981 Real (3)	% Change 1981-1982 Nominal (4)	% Change 1981-1982 Real (5)	% Change 1982-1983 Nominal (6)	% Change 1982-1983 Real (7)
1	United States	$20,209.4	17.30	7.42	6.37	-0.40	9.42	4.91
2	Alabama	224.1	12.82	3.32	7.42	0.58	10.75	6.18
3	Alaska	28.5	24.68	14.18	-1.13	-7.43	19.18	14.27
4	Arkansas	200.5	17.67	7.76	-2.52	-8.73	17.62	12.77
5	California	2478.0	19.66	9.58	1.64	-4.83	-0.86	-4.95
6	Colorado	159.9	15.39	5.67	10.19	3.17	11.45	6.86
7	Connecticut	295.4	13.14	3.61	16.40	8.99	11.83	7.22
8	Delaware	38.7	19.07	0.04	4.89	-1.79	6.82	2.42
9	District of Col.	140.8	6.29	-2.66	16.12	8.73	31.48	26.06
10	Florida	348.8	19.30	9.25	13.85	6.60	23.31	18.23
11	Georgia	389.3	17.97	8.03	6.37	-0.40	6.40	2.01
12	Hawaii	82.5	15.12	5.42	11.88	4.76	14.89	10.15
13	Idaho	46.0	13.99	4.39	-1.00	-7.30	12.41	7.78
14	Illinois	935.4	24.48	13.99	-2.25	-8.47	1.12	-3.05
15	Indiana	316.8	18.83	8.82	14.86	7.55	16.32	11.52
16	Iowa	199.4	16.35	6.55	5.61	-1.11	8.95	4.46
17	Kansas	165.5	14.27	4.64	5.79	-0.95	9.28	4.77
18	Kentucky	252.9	19.96	9.85	2.64	-3.90	17.52	12.67
19	Louisiana	344.6	12.20	2.75	23.88	15.99	15.11	10.36
20	Maine	122.8	12.56	3.08	11.03	3.96	13.36	8.69
21	Maryland	324.9	19.74	9.65	2.29	-4.22	15.30	10.56
22	Massachusetts	942.3	9.46	0.24	6.63	-0.16	11.13	6.55
23	Michigan	1,026.1	13.62	4.05	4.33	-2.31	2.93	-1.31
24	Minnesota	486.9	17.95	8.01	17.83	10.33	9.51	5.00
25	Mississippi	196.5	11.54	2.14	8.56	1.65	14.21	9.50
26	Missouri	214.4	28.01	17.23	8.83	1.90	19.97	15.02
27	Montana	54.0	27.11	16.40	1.03	-5.40	27.46	22.21
28	Nebraska	91.7	15.35	5.63	7.35	0.51	14.35	9.64
29	Nevada	32.4	37.95	26.33	5.95	-0.80	12.93	8.27
30	New Hampshire	61.2	17.25	7.37	3.91	-2.71	10.22	5.68
31	New Jersey	677.5	11.43	2.04	4.75	-1.92	12.88	8.23
32	New Mexico	59.2	23.20	12.82	9.34	2.38	3.55	-0.72
33	New York	3,606.8	18.61	8.62	10.00	3.00	9.42	4.91
34	North Carolina	342.3	18.37	8.40	1.58	-4.89	16.91	12.09
35	North Dakota	42.3	19.19	9.15	10.40	3.37	26.45	21.24
36	Ohio	676.0	24.34	13.86	19.82	12.19	16.49	11.69
37	Oklahoma	257.5	17.69	7.77	2.57	-3.96	4.97	0.64
38	Oregon	164.1	9.40	0.18	1.01	-5.42	11.75	7.14
39	Pennsylvania	1,132.3	14.34	4.71	10.96	3.90	6.87	2.46
40	Rhode Island	133.8	16.76	6.92	7.47	0.63	11.30	6.71
41	South Carolina	189.6	24.40	13.92	-3.39	-9.54	0.30	-3.84
42	South Dakota	49.4	20.29	10.12	8.03	1.15	0.97	-3.19
43	Tennessee	314.4	16.18	6.39	-6.07	-17.65	19.04	14.13
44	Texas	918.5	13.18	3.64	-1.58	-7.85	19.61	14.68
45	Utah	72.3	11.24	1.87	16.52	9.10	15.92	11.14
46	Vermont	53.0	15.68	5.93	9.22	2.27	4.74	0.42
47	Virginia	299.2	20.73	10.56	8.41	1.51	2.78	-1.46
48	Washington	300.4	18.03	8.09	-4.85	-10.91	5.92	1.55
49	West Virginia	91.9	17.25	7.37	-4.88	-10.94	19.77	14.83
50	Wisconsin	618.2	15.61	5.87	-0.27	-6.62	7.70	3.26
51	Wyoming	11.3	22.08	11.79	20.71	13.02	19.06	14.15

Source: HCFA-64 Expenditure Report

Figure 1


Medicaid Expenditures
Actual and Adjusted, 1974-83
Expenditures (Billions)
34
32
30
28
26
24
22
20
18
16
14
12
10
8
1974
1975
1976
1977
1978
1979
1980
1981
1982
1983
Actual
Adjusted for Inflation
(1978 Dollars)

The number of Medicaid recipients fell by 2.1 percent in 1982 after having risen by 2.4 percent per year from 1979 to 1981. Thirty-five of the fifty states had fewer recipients in 1982 than in 1981. Had the number of recipients declined and no changes occurred in Medicaid spending per recipient, the rate of increase in Medicaid spending would have dropped only to 12.1 percent in 1982, rather than to the 6.4 percent that actually occurred.

The remainder of the actual drop to 6.4 percent therefore reflects the decline in the rate of increase in spending per recipient. Expenditures per recipient grew 8.6 percent in 1982, after having risen by 14.5 percent annually in the two preceding years. Thirty-five states had lower growth rates in expenditures per recipient than in the past; twenty-two had real reductions in expenditures per recipient; and six actually spent less per recipient in nominal dollars in 1982 than they had spent in 1981.

What categories of Medicaid enrollees were most affected by spending reductions?

Medicaid covers three broad categories of people: the aged, the blind and disabled, and AFDC-related adults and children. States make Medicaid coverage available to persons in these categories when they are eligible for cash assistance (Supplemental Security Income in the first two categories, Aid to Families with Dependent Children in the last). States may provide Medicaid coverage to people in these categories when their income exceeds cash assistance standards, primarily through "medically needy" programs, operated by 30 states in 1982.

Between 1981 and 1982, numbers of enrollees declined for all three Medicaid groups: 5.3 percent for the AFDC adults and children, 4.7 percent for the aged, 1.4 percent for the blind and disabled. Table 2 provides information on expenditures and recipients for each group. Declines in recipients were somewhat smaller than for enrollees, 3.8 percent for AFDC children, 0 change for AFDC adults,* 2.2 percent for the aged and 1.0 percent for the blind and disabled. (See Figure 2.) The 1982 declines in recipients contrasted with annual increases for all categories between 1979 and 1981.

With the exception of AFDC children, all categories of Medicaid recipients experienced roughly similar rates of increase in spending per recipient (average 8.6 percent, range (excluding children): 7.7 percent for AFDC adults to 10.5 percent for the blind and disabled). For AFDC adults, the aged, and the blind and disabled, then, differences in rates of spending increase from 1981 to 1982 primarily reflected different changes in the number of people served, rather than in payments for services.

In contrast, children not only experienced the largest decline in numbers of recipients, but also a very low rate of increase in spending per recipient (1.9 percent). The combined result was that Medicaid actually spent 2 percent

---

*Recipient data report AFDC children and adults separately; eligibility data do not.

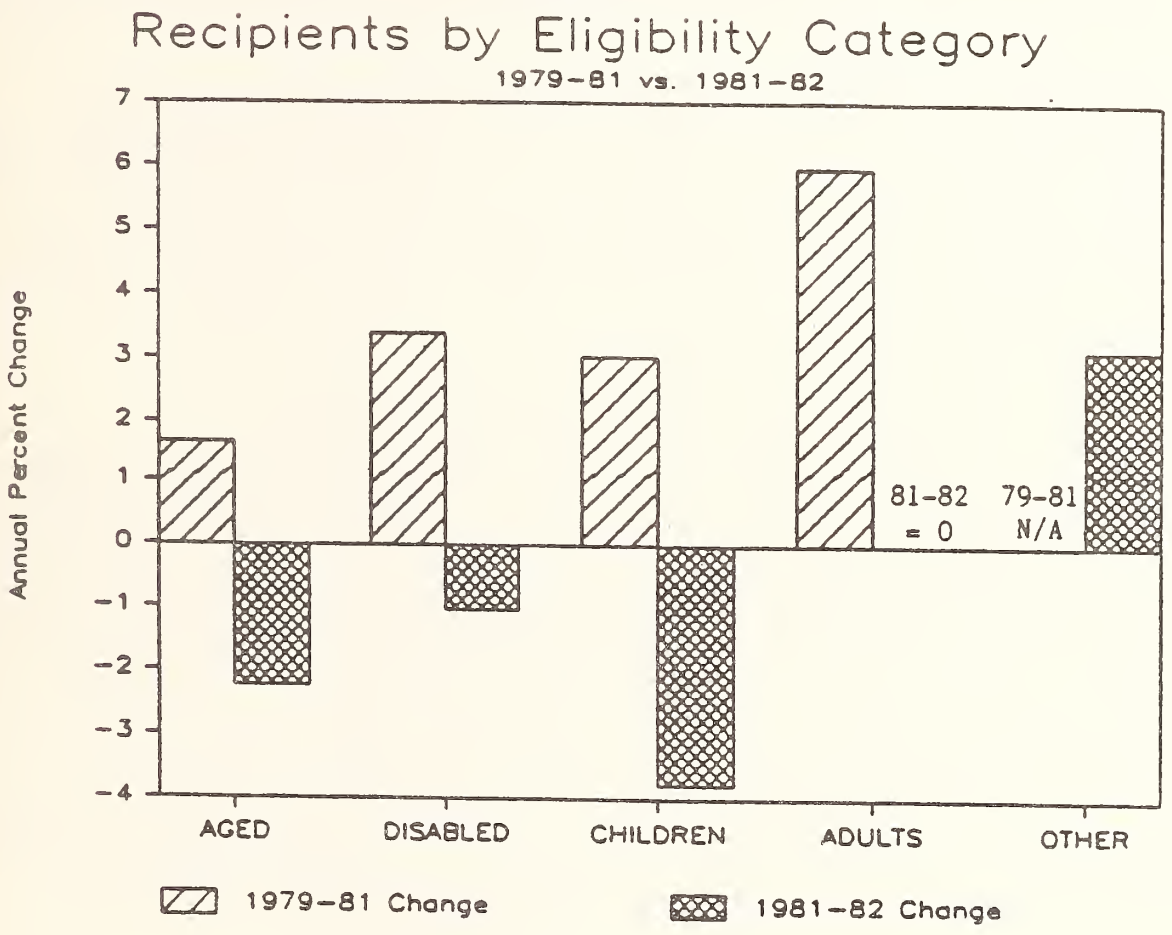
Table 2

Medicaid Recipients and Expenditures, By Eligibility Group,
1979 - 1982

	Recipients 1979 (in millions)	Expenditures 1979 (in millions)	Annual % Change Recipients		Annual % Change Expenditures/Recipient		Annual % Change Expenditures	
			1979-81	1981-82	1979-81	1981-82	1979-81	1981-82
Aged	3.4	7030.4	1.67	-2.23	18.25	8.13	20.22	5.72
Blind & Disabled	2.7	6792.6	3.38	-1.04	14.82	10.48	18.70	9.30
Children	8.7	2835.4	3.03	-3.79	8.75	1.85	12.04	-2.01
Adults	4.3	2967.4	5.96	0.00	7.71	7.71	14.14	7.71
Other Title XIX	1.1	1332.6	-	3.15	-	8.75	3.08	12.18
TOTAL	20.1	20,299.4	2.44	-2.06	14.50	8.60	17.30	6.37

Source: HCFA 2082 and HCFA 64 Expenditure Reports.

Figure 2


Recipients by Eligibility Category
1979-81 vs. 1981-82
Annual Percent Change
7
6
5
4
3
2
1
0
-1
-2
-3
-4
81-82 = 0
79-81 N/A
AGED
DISABLED
CHILDREN
ADULTS
OTHER
1979-81 Change
1981-82 Change

less on children in 1982 (in nominal terms) than the program had spent on children in the previous year.

By themselves, changes in numbers of Medicaid eligibles or recipients do not tell the full story of changes in Medicaid coverage of the poor. If numbers fall because there are fewer poor people, then no decline in coverage of the poor occurs. Alternatively, if numbers of eligibles or recipients fall despite an increase in numbers of poor people, then lower numbers mean less coverage for the poor.

How did the ratio of Medicaid enrollees to the poverty population change between 1981 and 1982?

Joel Cohen and John Holahan* estimate that the ratio of Medicaid enrollees to the poverty population fell 11.2 percent from 1981 to 1982. (See Figure 3.) In 1982, the ratio was 45 percent, down from 50.7 percent the year before. The aged (whose levels of coverage are highest to begin with) experienced the smallest drop (5 percent)—from 73.9 percent in 1981 to 70.2 percent in 1982. Children incurred the greatest decline, from 52.1 to 45.4 percent; followed closely by adults aged 21-64, whose coverage fell from 43.2 percent to 38.6 percent.

How did Medicaid spending changes vary across services?

Medicaid provides coverage for several very different kinds of health services. The services differ in terms of their importance to the program and states' ability and willingness to control their growth. Table 3 and Figure 4 provide information on expenditure increases for the 1979-1982 period for each major service category. For all Medicaid services, spending increased more slowly from 1981 to 1982 than in the previous two years, and rates of increase declined by more than 100 percent for physicians' services (16 percent, 1979-1981); -2.1 percent, 1981-1982) and dental care (14.6 percent 1979-1981; -10.0 percent, 1981-1982), and by almost 100 percent for drugs (15.8 percent, 1979-1981; 1.3 percent, 1981-1982). For physicians' services and dental care, these changes reflected almost no increase (.71 percent) and a decline (-5.3 percent), respectively, in spending per recipient—the lowest rates of change for all services. These services, along with several other optional Medicaid services, have been frequent targets of Medicaid cutbacks; in this sense, Medicaid programs behaved as they often had before.

Rates of increase for inpatient and outpatient hospital spending and for clinics fell to about a third of their former levels, due to declines in recipients and slower (by about half) rates of increase in spending per recipient. And the rate of increase in spending on ICF/MRs (though still substantial at 17.6 percent), decreased by 60 percent (due almost entirely to a very small increase in recipients, following two years of 33 percent annual

---

*Joel Cohen and John Holahan, "Medicaid Eligibility After the Omnibus Budget Reconciliation Act of 1981," MPE Working Paper 5.1.

Figure 3

Medicaid Enrollees As A Percentage of Persons
In Poverty (31 States)

Eligibility Category	1981	1982	% Change, 1981-1982
Total	50.7	45.0	-11.2
Aged	73.9	70.2	- 5.0
Children	52.1	45.4	-12.8
Adults	43.2	38.6	-10.6

Source: Medicaid Enrollees--Health Care Financing Administration, "Monthly Statistical Report on Medical Care," Form HCFA-120, October 1980 through September 1982. Persons in Poverty--Urban Institute TRIM2 Simulations.

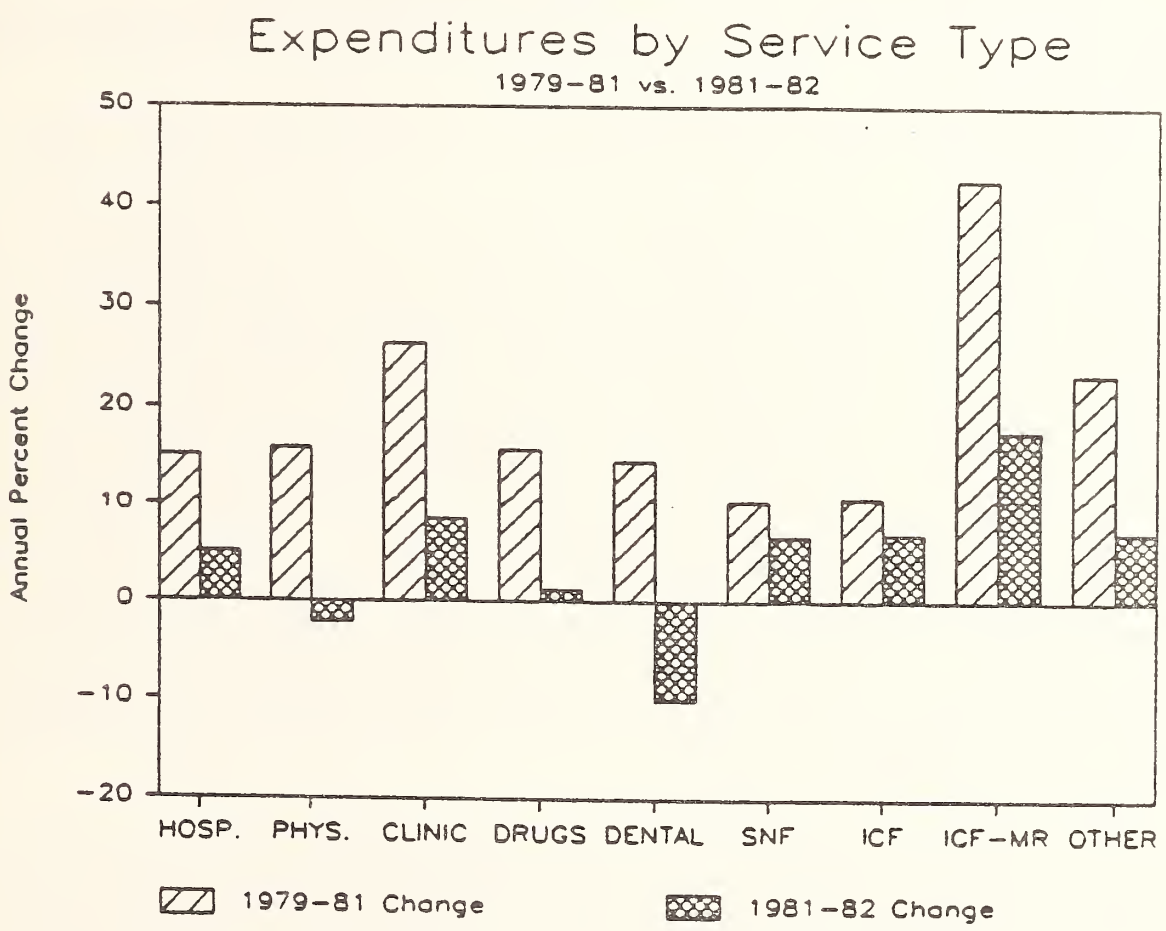
Table 3

Average Annual Increases
Medicaid Recipients and Expenditures, By Service
United States 1979 - 1982

	Recipients 1979 (in millions)	Expenditures 1979 (in millions)	% Change Recipients		% Change Expenditures Per Recipient		% Change Expenditures	
			1979-81	1981-82	1979-81	1981-82	1979-81	1981-82
Hospital Inpatient Care	3.5	5558.9	-0.70	-3.08	16.03	8.51	15.22	5.17
Physician Services	13.8	1785.3	2.98	-2.83	12.60	.71	15.96	-2.14
Clinic and OHS	9.2	1106.9	6.78	-0.68	18.31	9.32	26.33	8.57
Drugs	13.4	1171.0	3.55	-4.04	11.82	5.54	15.78	1.27
Dental Care	4.3	426.0	9.55	-5.00	4.59	-5.31	14.58	-10.04
SNF	0.6	3335.4	-0.10	-6.49	10.52	14.16	10.41	6.75
ICF	0.8	3789.5	0.62	-0.61	10.14	7.68	10.82	7.02
ICF-MR	0.1	1479.5	22.79	3.80	16.08	13.30	42.53	17.60
All Other	6.8	807.9	18.48	-2.03	4.15	9.47	23.40	7.25
TOTAL	20.1	20,209.4	2.44	-2.06	14.50	8.60	17.30	6.37

Source: HCFA-64 and HCFA-2082 Expenditure Reports

Figure 4


Expenditures by Service Type
1979–81 vs. 1981–82
Annual Percent Change
50
40
30
20
10
0
–10
–20
HOSP.
PHYS.
CLINIC
DRUGS
DENTAL
SNF
ICF
ICF–MR
OTHER
1979–81 Change
1981–82 Change

growth). Control over these expenditure areas represents a real departure from past experience.

Nursing homes experienced the smallest decline in growth rates after 1981--increasing by 7 percent from 1981 to 1982, as compared with about 10 percent annually in the two previous years. In fact, nursing homes were the only service for which rates of increase in spending per recipient barely slowed in 1982. This outcome probably reflects the fact that states had achieved a reasonable degree of control over nursing home expenditure growth prior to this period.

Factors Explaining Lower Rates of Spending Increase in 1982

The spending changes just described were largely a function of changes in state policy in response to the recession and federal policy changes instituted by OBRA.

How much did OBRA, independent of the recession, contribute to the results?

One way to answer this question is to examine how states' Medicaid spending levels vary with economic conditions, which affect the numbers of persons enrolled in Medicaid and states' ability to finance service, and with different levels of federal matching rates, which basically alter the price states pay from their own resources to finance Medicaid service. The recession affected the first; OBRA affected the second. Specifically, OBRA reduced the share of Medicaid expense the federal government would pay by 3 percent in FY 1982, 4 percent in FY 1983 and 4.5 percent in FY 1984. OBRA also allowed states to avoid federal reductions under certain circumstances. In states that kept their 1982 spending below a target amount (9 percent of previously projected FY 1981 spending), savings below the target would offset the federal cuts, dollar for dollar. In addition, the federal government would reduce its 3 percent cut for a state by one percentage point for each of the following: (1) previously approved hospital rate-setting programs, (2) unemployment rates over 150 percent of the national average, or (3) savings of more than one percent of the federal share, due to fraud and abuse or third party recovery programs.

Multivariate analysis was employed to distinguish the effect of OBRA's change in the federal match from the recession and from other factors likely to affect spending (especially the supply of medical services--providers per capita; and demographic factors affecting the demand for Medicaid services). The analysis used Medicaid 2082 data for 50 states from 1979 through 1982. Means and standard deviations of the variables used in the analysis are provided in Table 4.

The results of the analysis are shown in Table 5. The dependent variables are Medicaid spending per capita for all services and for expenditures per capita for all services and for expenditures per capita for acute and long-term care. The recession effect was indicated by an income variable measured as real income per taxpayer. The income variable captures three effects. The most important is the effect of income on the willingness to

Table 4

Means and Standard Deviations of Variables

Variable	Acronym	Mean	Standard Deviation
Total Medicaid Expenditures Per Capita	TMEDEXP	81.95	36.53
Total Acute Care Expenditures Per Capita	TACEXP	41.39	25.03
Total Long Term Care Expenditures Per Capita	TLTCEXP	40.56	18.93
Total Expenditures Per Capita --Aged	TAGEDEXP	31.43	13.82
Total Expenditures Per Capita —Blind & Disabled	TBDEXP	27.33	14.10
Total Expenditures Per Capita --Adults & Children	TAFDCEXP	23.18	14.76
Percent of State Population under 18	PUND18	.287	.023
Percent of State Population over 75	POV75	.043	.010
Percent of State Population Finishing High School	PFINHS	.673	.075
Percent of State Population Non-White	PNONWH	.156	.143
Percent of State Population Living in Urban Area	PURBAN	.673	.148
Physicians Per 10,000 Persons	MDS	14.48	4.88
Hospital Beds 10,000 Persons	HBEDS	45.72	10.24
Nursing Home Beds Per 1,000 Elderly Persons	NHBEDS	57.78	18.87
Real Income Per Taxpayer	INCTAXP	$15347.87	$1170.58
Federal Matching Rate	FEDMATCH	.587	.081

Note: All Expenditure Variables and Income Per Taxpayer are deflated to 1979 dollars.

Table 5

Determinants of State Medicaid Spending - Regression Results:
Total, Acute Care and Long Term Care Expenditures[a]
(T-ratios in parentheses)

Dependent Variables

	TMEDEXP		TACEXP		TLTCEXP	
	(1)	(2)	(1)	(2)	(1)	(2)
Intercept	-11.86** (-2.18)	-13.46** (-2.10)	-4.32 (-0.69)	-8.31 (-1.17)	-8.32 (-1.60)	-11.09* (-1.89)
INCTAXP	1.15** (2.08)	1.72** (2.72)	0.55 (0.88)	1.16* (1.65)	1.02* (1.86)	1.70** (2.80)
FEDMATCH	0.95** (2.38)	1.31** (2.98)	0.29 (0.65)	0.90* (1.90)	0.50 (1.49)	0.84** (2.24)
PUND18	-0.91 (1.60)	-1.57*** (-2.90)	-0.15 (-0.24)	-2.06*** (-3.90)	— —	— —
POV75	-0.19 (-1.63)	-0.02 (-0.14)	0.87* (1.87)	1.57*** (3.11)	-0.26 (-0.51)	1.20** (2.32)
PFINHS	-0.79** (-1.96)	-0.34 (-0.73)	-1.65*** (-3.65)	-1.47*** (-2.88)	-0.21 (0.44)	0.44 (0.82)
PNONWH	0.08** (2.17)	0.09** (2.00)	0.16*** (3.78)	0.22*** (4.67)	0.04 (0.77)	0.02 (0.32)
PURBAN	-0.26* (-1.70)	0.13 (0.80)	-0.26 (-1.57)	0.11 (0.66)	-0.005 (-0.03)	0.04 (0.22)
MDS	0.99*** (7.07)	— —	1.11*** (7.26)	— —	— —	— —
HBEDS	-0.05 (-0.37)	— —	0.03 (0.21)	— —	— —	— —
NHBEDS	0.38*** (5.68)	— —	— —	— —	0.58*** (7.15)	— —
EAST	0.11 (1.32)	0.28*** (3.81)	0.11 (1.11)	0.40*** (4.87)	0.45*** (6.20)	0.35*** (4.36)
SOUTH	-0.30*** (-3.32)	-0.42*** (-4.13)	-0.32*** (-2.94)	-0.35*** (-2.98)	-0.07 (0.68)	-0.15 (-1.27)
WEST	-0.17* (-1.91)	-0.25*** (-2.76)	0.02 (0.23)	0.12 (1.12)	-0.20** (-2.04)	-0.27* (-2.41)
1980	0.03 (0.66)	0.08 (1.26)	0.04 (0.67)	0.09 (1.31)	0.05 (0.88)	0.06 (0.88)
1981	0.09 (1.49)	0.19*** (2.79)	0.06 (0.92)	0.17** (2.36)	0.14* (2.12)	0.18* (2.35)
1982	0.15** (2.00)	0.26*** (3.10)	0.05 (0.63)	0.19** (2.00)	0.22** (2.72)	0.28*** (3.16)
$\bar{R}^2$	0.61	0.46	0.64	0.54	0.50	0.36

a. Column 1 presents full model. Column 2 presents estimates for income and the federal match excluding the provider availability variables (MDS, HBEDS, and NHBEDS).

* Significant at the .10 level.
** Significant at the .05 level.
*** Significant at the .01 level.

spend on Medicaid. Increases in taxpayer income increase state revenues (increasing budget surpluses or decreasing deficits), permitting higher expenditures. Offsetting this effect is the fact that the income variable is correlated with poverty and thus need. As income declines, the need for services and Medicaid enrollment should increase. (A separate measure of need, such as the percentage of the population in poverty, was not included in the analysis because of its high correlation with income.)

The hypothesized effect of increased need on expenditures is the opposite of the effect of reduced tax revenues--potentially inhibiting conclusion results. It is not clear how serious this problem is. States with high poverty populations tend to have lower Medicaid spending.* Moreover, during the recent recession, Medicaid payment standards were frozen in many states while poverty rates were increasing even prior to OBRA.** Thus, states do not appear to respond in a clear way to need. More likely, there is a queue of needy individuals in every state. The model used here assumes that how far down this queue a state goes is determined by income, price, etc.

The income variable is significant in the total expenditure equations with an elasticity of 1.2 to 1.7 depending on the specification, meaning that a 1 percent reduction in real income per taxpayer would lead to a 1.2 to 1.7 percent drop in Medicaid expenditures. The variable is significant in both long-term care equations but in only one acute care relationship. The elasticities in the long-term care equation were 1.0 and 1.7. While the elasticities are somewhat different, the results indicate long-term care spending is quite responsive to income.

The federal matching rate is also positively related to Medicaid expenditures but is less often significant and has lower elasticities than the income variable. This small impact is not surprising, given the small reduction in rates (see below on offsets to reductions) and the weak incentives in the structure. (See Stephen H. Long and Russell F. Settle, "Federal Financial Participation in Medicaid Under the Reagan Administration: A Conceptual Evaluation," MPE Working Paper 7.5.) Below the target rate of spending set by OBRA (in 1982, 109% of estimated 1981 expenditures) and a lower level at which the reduction was totally offset, states received the same amount of federal money no matter what they spent. In this range, then, OBRA effectively placed a cap on the federal share of Medicaid expenses, and states would benefit 100 percent from any savings they could induce. Once total spending exceeded the capped range, OBRA reduced Medicaid spending only modestly, from 50 to 48.5 percent for high income states and from 78 to a minimum of 75.66 percent for the lowest income states.

---

*Jerry Cromwell et al., "The Evolution of State Medicaid Programs," Center for Health Economics Research, June 1984.

**Ian Hill, "Medicaid Eligibility: A Descriptive Report of OBRA, TEFRA, and DEFRA Provisions and State Responses," Syracuse University, October 1984.

Although the "cap" theoretically created a strong incentive to control costs, it is difficult to believe that states could fine tune their behavior in the narrow range over which this incentive applied. The combination of a very narrow range for the cap and only a modest reduction in the federal share overall implies that OBRA's modifications offered little incentive for states to slow the rate of growth in Medicaid spending.

In sum, then, the analysis shows that:

- both economic conditions (measured in terms of income per taxpayer) and the federal matching rate have an impact on Medicaid spending;
- the impact of economic conditions is stronger; and
- a decline in economic conditions (measured in terms of income per taxpayer) reduces Medicaid spending, despite the fact that numbers of poor people increase.

The data set used in the analysis is such that the cross-section effects dominate the time series. Thus, it is risky to infer from these findings the impact of changes in explanatory variables on expenditures in the short term. If, however, we assume the short-term responses are consistent with the findings reflected in our cross-sectional estimates, then the inference can be made that the recession was more important than OBRA's matching rate reductions in influencing Medicaid spending between 1981 and 1982.

This would be true for two reasons. One is that the reduction in income per taxpayer in 1982 was greater for the nation than the average reductions in matching rates. The other is that the income elasticities were somewhat larger than those for the matching rate. The impact of income appears to be roughly twice as large as that of the matching rate. The recession appears to have reduced real spending by about 4 percent while the matching rate reduction reduced real expenditures by less than 2 percent. Although their effect on spending appears to be smaller, matching rates nonetheless appear to be a useful public policy tool for controlling Medicaid expenditures.

Although no effort was made to model the impact of OBRA's specific policy change, the analysis tested whether 1982 spending was "different" from other years, that is, less amenable to explanation by economic activity or matching rates; or the other facts for which the model controlled. The hypothesis was that if OBRA's new flexibility allowed states better than previous control over spending, the year would have a statistically significant negative impact on state spending. However, the year variable also captures the excess of medical price inflation over general inflation—in 1982, an excess of about 5 percent. If increases in medical prices heavily influenced Medicaid spending, the 1982 variable would have a significant positive impact.

In fact the time variable was not significant in explaining levels of Medicaid spending on acute care. The fact that the time variable in 1982 was not significantly different from zero in a year of particularly large medical care price inflation suggests that states may have been more successful in

controlling acute care expenditures than they might have been without OBRA. This suggests that 1982 may have seen either greater control over payment rates, or reductions in eligibility or utilization rates which overcame medical care price increases. That is, without OBRA, acute care expenditures may have risen at higher rates than were observed.

In the long-term care equation, the 1982 time variable indicated that spending was about 8 percent higher in 1982 than in 1981, all else being equal. Long-term care is an area that was not directly affected by OBRA's changes in eligibility. Increases in long-term care expenses over time suggest that states may substitute Medicaid for other state spending (a phenomenon encouraged by OBRA's Section 2176) or a willingness to allow spending to increase (regardless of income or price) for long-term care services.

How did the matching formula's components affect payments to the states and net federal savings?

The 1981 OBRA legislation reduced federal Medicaid contributions by 3 percent in FY 1982, 4 percent in FY 1983, and 4.5 percent in FY 1984. But states could avoid these reductions by keeping their spending growth between 1981 and 1982 below a "target rate"--109 percent of 1982 spending, as estimated in April of 1981. The target was based on an estimate to avoid "gaming" of the system; e.g., if the target was based on actual spending, states could increase the rate at which bills were paid, thereby increasing the 1982 base and easing the task of living within the target. The target for 1983 was based on the increase in the medical care component of the CPI and permitted states an increase of 7.5 percent above their 1982 targets.

The effect of the calculation procedure is that a state could receive a rebate even if its actual expenditures increased at a rate in excess of 9 percent. This would occur if the state's actual 1982 expenditures were less than the April 1981 estimate for 1982. In addition, some states could have had actual expenditure growth below 9 percent and not receive a rebate. This could occur if actual 1982 expenditures exceeded the estimated expenditures.

Tables 6 and 7 show the 1982 and 1983 target expenditures by state, respectively, as well as actual expenditures, various offsets, incentive rebates, and federal savings for both years. Incentive rebates refer to the recoupment by states of lost "matching funds" by keeping expenditures below the target, while federal savings refers to net reduction in federal matching contributions. Table 6 shows that 31 states received incentive rebates, while Table 1 indicated 33 states had actual rates of increase in spending below 9 percent.

In 1983, the target growth rate was 7.5 percent above the 1982 target. A state which kept its 1982 expenditures below the 1982 target could have 1983 expenditure growth above 7.5 percent and still stay below the 1983 target. In other words, success in expenditure control in 1982 made it easier to earn rebates in 1983. The result was that only 13 states had expenditure growth between 1982 and 1983 below 7.5 percent, but 26 states received incentive rebates.

Table 6

Impact of Federal Matching Contribution Reductions, by State, 1982

	State Expend.	Target	Gross Reduct.	Offsets			FY 1982 Incentive Rebate	Federal Net Savings
				TPL/F&A	Hosp.	Unemp.		
Alabama	$ 241,017	$ 245,200	$ 7,027	$ 2,342	$ 0	$ 623	$ 4,062	$ 0
Alaska	20,294	24,138	653	0	0	0	653	0
Arkansas	212,115	244,044	6,322	0	0	0	6,322	0
California	2,150,066	2,218,030	63,291	21,097	0	0	42,194	0
Colorado	136,604	131,881	4,208	1,403	0	0	0	2,805
Connecticut	229,670	212,247	6,896	2,299	2,299	0	0	2,298
Delaware	30,121	32,728	904	0	0	0	904	0
Dist. of Col.	91,834	103,537	2,877	0	0	0	2,877	0
Florida	355,319	350,649	10,667	3,556	0	0	0	7,111
Georgia	402,447	413,496	12,026	4,009	0	0	8,017	0
Hawaii	66,585	63,016	1,963	654	0	0	0	1,309
Idaho	41,878	45,927	1,254	418	0	0	836	0
Illinois	763,107	824,917	22,862	2,030	0	0	20,832	0
Indiana	298,431	282,850	8,942	0	0	0	0	8,942
Iowa	169,492	165,685	5,023	1,674	0	0	0	3,349
Kansas	128,988	133,719	3,858	1,286	0	0	2,572	0
Kentucky	276,141	285,375	8,267	0	0	0	8,267	0
Louisiana	395,700	365,818	11,948	0	0	0	0	11,948
Maine	137,300	123,536	4,054	1,351	0	0	0	2,703
Maryland	250,885	267,693	7,599	2,533	2,533	0	2,533	0
Massachusetts	690,563	685,728	21,287	0	7,095	0	0	14,192
Michigan	760,489	772,409	22,612	7,537	0	7,537	7,538	0
Minnesota	446,720	427,024	13,401	4,467	0	0	0	8,934
Mississippi	218,295	221,066	6,460	2,153	0	0	2,771	1,536
Missouri	257,138	287,355	7,596	0	0	0	7,596	0
Montana	46,458	49,170	1,602	534	0	0	1,068	0
Nebraska	88,774	89,548	2,659	886	0	0	774	999
Nevada	37,093	32,689	1,103	368	0	0	0	735

Table 6 (continued)

	State Expend.	Target	Gross Reduct.	Offsets			FY 1982 Incentive Rebate	Federal Net Savings
				TPL/F&A	Hosp.	Unemp.		
New Hampshire	55,664	61,358	1,670	273	0	0	1,397	0
New Jersey	478,467	507,408	14,231	3,826	4,744	0	5,661	0
New Mexico	71,422	72,089	2,125	708	0	0	667	750
New York	3,110,469	2,862,705	91,809	30,603	30,603	0	0	30,603
North Carolina	343,296	376,249	10,358	3,453	0	0	6,095	0
North Dakota	44,100	42,763	1,337	446	0	0	0	891
Ohio	728,603	688,492	21,830	0	0	0	0	21,830
Oklahoma	240,309	248,244	7,195	721	0	0	6,474	0
Oregon	124,697	134,552	3,734	1,245	0	0	2,489	0
Pennsylvania	960,839	925,165	29,502	2,491	0	0	0	27,011
Rhode Island	119,815	114,186	3,570	0	1,190	0	0	2,380
South Carolina	208,809	224,578	6,301	0	0	0	6,301	0
South Dakota	53,361	47,453	1,609	536	0	0	0	1,073
Tennessee	290,513	353,634	8,648	0	0	0	8,648	0
Texas	679,010	819,841	20,379	0	0	0	20,379	0
Utah	77,768	79,960	2,358	786	0	0	1,572	0
Vermont	56,977	59,012	1,711	0	0	0	1,711	0
Virginia	301,821	286,188	8,995	0	0	0	0	8,995
Washington	225,805	239,271	6,704	2,235	2,235	0	2,234	0
West Virginia	91,096	97,871	2,723	0	0	0	2,723	0
Wisconsin	501,705	582,278	15,200	1,259	0	0	13,941	9
Wyoming	10,754	10,067	323	108	0	0	0	215
Total	$17,718,824	$17,931,939	$529,673	$109,287	$50,699	$ 8,160	$200,918	$160,609

Source: Medicaid Financial Highlights Department of Health and Human Services, Health Care Financing Administrator, Bureau of Program Operations, Vol. 1, No. 4, March 1984

Table 7

Impact of Federal Matching Contribution Reductions, by State, 1983

	State Expend.	Target	Gross Reduct.	Offsets			FY 1983 Incentive Rebate	Federal Net Savings
				F&A	Hosp.	Unemp.		
Alabama	$ 253,067	$ 263,590	$ 10,132	$ 0	$ 0	$ 805	$ 9,327	$ 0
Alaska	24,691	25,948	1,020	0	0	0	1,020	0
Arkansas	240,631	262,347	9,665	0	0	0	9,665	0
California	2,132,288	2,384,382	84,843	21,211	0	0	63,632	0
Colorado	145,768	141,772	5,863	0	0	0	0	5,863
Connecticut	259,397	228,166	10,381	0	2,595	0	0	7,786
Delaware	32,279	35,183	1,292	0	0	0	1,292	0
Dist. of Col.	127,343	111,302	5,118	0	0	0	0	5,118
Florida	435,869	376,948	17,433	4,358	0	0	0	13,075
Georgia	426,332	444,508	17,074	0	0	0	17,074	0
Hawaii	74,256	67,742	2,995	749	0	0	0	2,246
Idaho	46,358	48,404	1,874	0	0	0	1,874	0
Illinois	762,299	886,786	30,517	0	0	0	30,517	0
Indiana	344,539	304,064	13,769	0	0	0	0	13,769
Iowa	178,795	178,111	7,161	0	0	0	0	7,161
Kansas	138,137	143,748	5,602	0	0	0	5,602	0
Kentucky	305,123	306,778	12,227	0	0	0	1,655	10,572
Louisiana	428,430	393,254	17,245	0	0	0	0	17,245
Maine	148,875	132,801	6,030	0	0	0	0	6,030
Maryland	294,032	287,770	11,808	0	2,952	0	0	8,856
Massachusetts	720,682	737,158	30,296	0	7,574	0	16,476	6,246
Michigan	784,740	830,340	31,322	0	0	5,941	25,381	0
Minnesota	488,760	459,051	19,549	0	0	0	0	19,549
Mississippi	247,453	237,646	9,917	0	0	0	0	9,917
Missouri	302,413	308,097	12,193	0	0	0	6,494	5,699
Montana	66,043	52,858	2,657	139	0	0	0	2,518
Nebraska	98,132	96,264	3,932	742	0	0	0	3,190
Nevada	40,292	35,141	1,611	0	0	0	0	1,611

Table 7 (continued)

	State Expend.	Target	Gross Reduct.	Offsets			FY 1982 Incentive Rebate	Federal Net Savings
				TPL/F&A	Hosp.	Unemp.		
New Hampshire	58,901	65,960	2,395	0	0	0	2,395	0
New Jersey	526,027	545,464	21,437	0	5,359	0	16,078	0
New Mexico	75,347	77,496	3,011	753	0	0	2,149	109
New York	3,260,310	3,077,408	133,879	33,470	33,470	0	0	66,939
North Carolina	394,181	404,468	15,691	0	0	0	10,287	5,404
North Dakota	54,009	45,970	2,187	0	0	0	0	2,187
Ohio	850,302	740,129	34,164	0	0	0	0	34,164
Oklahoma	256,415	266,862	10,280	0	0	0	10,280	0
Oregon	139,281	144,643	5,580	0	0	0	5,362	218
Pennsylvania	1,021,186	994,552	42,211	0	0	0	0	42,211
Rhode Island	132,730	122,750	5,300	0	1,325	0	0	3,975
South Carolina	210,996	241,421	8,463	0	0	0	8,463	0
South Dakota	54,322	51,012	2,266	0	0	0	0	2,266
Tennessee	348,919	380,157	13,044	0	0	0	13,944	0
Texas	826,376	881,329	33,193	0	0	0	33,193	0
Utah	91,981	85,057	3,706	926	0	0	0	2,780
Vermont	60,233	63,438	2,451	0	0	0	2,451	0
Virginia	297,562	307,652	11,921	0	0	0	10,090	1,831
Washington	223,927	257,216	8,997	0	0	0	8,997	0
West Virginia	105,218	105,211	4,244	0	0	801	0	3,443
Wisconsin	546,873	625,949	21,935	0	0	0	21,935	0
Wyoming	12,717	10,822	509	0	0	0	0	509
Total	$19,094,836	$19,276,835	$771,290	$ 62,348	$53,275	$ 7,547	$335,633	$312,487

Source: Medicaid Financial Highlights Department of Health and Human Services, Health Care Financing Administrator, Bureau of Program Operations, Vol. 1, No. 4, March 1984

In Tables 6 and 7, the column labeled Gross Reduction reflects the 3 percent and 4 percent matching contribution reductions in 1982 and 1983, respectively. The next three columns provide data on fraud and abuse, hospital rate setting, and unemployment offsets. States meeting the criteria for any of these offsets had the matching contribution reductions "offset" by 1 percentage point. In 1982, the federal government permitted states to count third-party liability recoveries as fraud and abuse savings. The result was that 33 states received the 1 percent fraud and abuse offset. Twenty of these states would have been eligible for the incentive rebates, however, because expenditures increased by less than their targets. In 1983, third-party recoveries were not included and only eight states received the 1 percent fraud and abuse offset.

In 1982, seven states received the hospital cost-containment offset; in 1983, only six states were eligible. In 1982, Michigan and Alabama (one-quarter) received the unemployment rate offset; in 1983, Michigan, Alabama, and West Virginia received full or partial unemployment rate offsets.

The U.S. totals for gross reductions in matching funds increased from $530 million in 1982 to $771 million in 1983 because of increases in state expenditures and because of the increase in the reduction rate. The fraud and abuse offset fell by $47 million while the hospital cost-containment and unemployment offsets increased slightly. The incentive rebates increased from $201 million in 1982 to $336 million in 1983 because of the higher gross reductions, the reduced fraud and abuse offsets, and the relatively large number of states (26) eligible for them. While seven fewer states received rebates, the increased expenditure levels involved resulted in increased aggregate rebates.

When states did not receive the full offsets and/or failed to meet their expenditure targets, the federal government saved money from lower matching rates. Net federal savings from paying lower rates amounted to $160,609,000 in 1982. Federal savings increased to $312,487,000 in 1983. These savings are in addition to the direct effect of reduced matching rates on state spending revealed by the multivariate analysis.

Did spending restraint persist after 1982?

Medicaid spending began to increase in real terms again in 1983. Expenditures increased nationally by 9.4 percent or by 4.9 percent in real terms compared to the -0.4 real decline in 1982. Thirty-seven states had higher rates of increase in 1983 than in the previous year, and thirty-six states had rates of increase in real spending of greater than 4 percent. In fact, the national rate appears to have been as low as it was largely because of continued low growth rates in such large states as California (.9%), Illinois (1.1%), Michigan (2.9%), Pennsylvania (6.9%), and New York (9.4%).

Is this a return to earlier spending trends?

It is difficult to draw conclusions from behavior one year after such a dramatic decline in Medicaid spending. The 1982 cuts may have been too difficult to sustain, even if there is to be some slowdown in the future.

Furthermore, beyond eligibility changes, OBRA's policy initiatives were still in the early stages of implementation in 1983--too new and too limited to have much effect. Hence, it may be too soon to judge what the future will bring.

Nevertheless, the recovery of Medicaid spending with the recovery of the economy suggests that fiscal pressure may still be the primary determinant of Medicaid spending although the OBRA policy changes may have given states greater ability to contain Medicaid costs.

II. STATE REACTIONS TO CHANGES IN FEDERAL POLICY

To better understand how states respond to changes in federal policy and other pressures upon them, this chapter examines in broad terms states` approaches to Medicaid cost containment after 1981. First, we examine how states treated Medicaid in the budget process. How did Medicaid fare relative to other programs? Under what circumstances did states aggressively limit their Medicaid spending?

Second, we explain how states who successfully limited spending in 1982 achieved these goals. What policies did they pursue? Were they using new policy options authorized by OBRA or old options that were available before?

Third, we look specifically at states' responses to OBRA`s policy changes. How did states respond to mandatory policy changes and options (with or without waivers) to take new approaches? Which options were attractive? Which were not? How many states introduced "innovative" policies?

Medicaid in the Budget Process

In "State Budget Priorities and Medicaid" (MPE Working Paper 7.2) Walter G. Davis, Jr. and Teri A. Gullo examined Medicaid's place in state budget making in 17 states from FY 1980 to FY 1983. States in the sample were Alabama, California, Colorado, Idaho, Illinois, Kansas, Kentucky, Massachusetts, Michigan, Mississippi, Missouri, New Jersey, New York, Ohio, Pennsylvania, Texas, and Vermont. Rates of change in Medicaid spending were compared to rates of change in total state spending and to spending in other program areas.

How did Medicaid fare relative to other state spending?

The study found that in the early 1980s, states were slow to control Medicaid spending--allowing Medicaid spending to increase faster than state spending as a whole, much faster than spending on other programs* in FY 1980 to 1981, and faster than spending in all programs except elementary and secondary education and criminal justice during 1981 to 1982. In that year, when total state spending was dropping in inflation-adjusted terms, study states increased spending only for Medicaid (0.61 percent), criminal justice (3.1 percent) and elementary and secondary education (6.0 percent) after adjusting for inflation.

By 1983, however, states had stopped giving Medicaid preference. Between 1982 and 1983, Medicaid spending grew substantially more slowly than total state spending and was one of only three programs allowed to decline. The

---

*Other functions include: social services, income support, health (other than Medicaid), elementary and secondary education, higher education and criminal justice--60 percent of all state spending and a much larger share of non-administrative expenses.

three programs that declined (Medicaid, social services and income support) were all welfare-related. (See Table 8.)

Under what circumstances do states limit Medicaid spending?

The decline in Medicaid's position relative to total state spending and other programs may not be common across all states. Instead, the change in average patterns appears to be largely a function of changes in behavior in fiscally stressed states. Twelve of the 17 states provided sufficient data to allow a comparison of spending patterns in fiscally stressed with patterns in non-stressed states.*

The comparison showed that for 1982-1983 states without fiscal stress allowed Medicaid spending to increase faster than total spending and spending in almost all program areas (except social services), just as similar states did in 1981-1982. In contrast, by 1982-1983 fiscally stressed states held Medicaid spending (along with spending on other welfare-related programs) down in real terms, even though total state spending was growing.

Medicaid's place in state budgets suggests that: (1) states find Medicaid an attractive area to spend (or a difficult area to control) and (2) states can control Medicaid spending when they have to. Medicaid's attractiveness relative to other programs derives primarily from the open-ended federal match in funds available to finance health care. Because of this match, the state can buy far more than a dollar's worth of care for every dollar it spends. It can also buy Medicaid-covered services more cheaply than services in areas with little federal funding. As a result, then, not only is Medicaid spending likely to increase faster than spending in other areas (with less favorable or no federal funds), but Medicaid spending may also absorb services from other program areas (like health or social services), where the latter are more heavily state-financed.

At the same time these factors make Medicaid attractive, other factors make Medicaid spending difficult to control. In contrast to other state activities, Medicaid entitles people to service and assumes liabilities for service used at specified prices or rates (or, for some services, at costs). Expenditures that are a function of beneficiaries' and providers' behavior, rather than simply of state appropriations, are not easy to control.

Medicaid's attractiveness and complexity, then, help explain its relative growth. But the reversal of that pattern by 1983 suggests that when fiscal pressure makes it essential, states can and will control Medicaid spending.

---

*States were classified as stressed when they experienced a large "expenditure gap," that is, when revenues fell more than 5 percent short of levels needed to maintain program expenditures at existing levels.

Table 8

Average Real Changes in Spending, by Function*
(12-State Sample)

	1980-81	1981-82	1982-83
Total Expenditures	-0.27%	-4.34%	2.13%
Medicaid[a]	(8.05)	(0.61)	(-1.00)
E&S Education	-2.37	5.97	0.94
Higher Education	-0.42	-2.94	0.60
Health	1.48	-2.94	0.60
Social Services	4.90[b]	-6.72	-1.00
Income Support	3.12	-0.36	-2.72
Criminal Justice	0.27	3.10	5.37

*Data sources include state budgets, financial reports, and legislative reports. Because of differences of treatment of Medicaid expenditures among states, Medicaid figures reported here are HCFA data adjusted for state fiscal years.

State Policy Choices

Once they decide to control Medicaid spending, how do states do it?

State policies help to determine how many people will receive Medicaid-covered services, how much service they are likely to receive, and how much providers will get paid for services rendered. Although federal law and policy establish ground rules for state choices, states have always had the ability to affect eligibility levels (through their determination of AFDC eligibility levels or "payment standards"); to limit payments to most providers (with the important exception of hospitals); and to limit days or visits covered.

For 1982 and beyond, however, OBRA gave the states several new means for containing costs. One set was mandatory. Federal law prohibited AFDC (and thereby potentially Medicaid coverage) to 19-21 year olds attending school and to persons whose earned income exceeded specified amounts; reduced the income states could "disregard" in determining eligibility; and established uniform limits on assets people could have and be eligible for AFDC/Medicaid. Other changes were optional. In eligibility, states were allowed (rather than required) to cover persons ages 18 to 21 not receiving AFDC who would be eligible for AFDC if they were under age 18 or in school; and to vary the scope of "medically needy" coverage for different categories of eligibles.

On payment, states were allowed greater leeway to control payments to hospitals, where previously almost all states had used the Medicare method and paid "reasonable" costs. Although states could depart from this practice (with HCFA approval) prior to OBRA, the new law allowed a broader array of acceptable payment methods and HCFA accepted more than instructed state policy choices.

On delivery and use, OBRA loosened interpretation of "freedom of choice" by allowing states to enter into competitive bidding to purchase laboratory services or medical supplies; to restrict to specified providers (or "lock in") recipients identified as overusers; and to ban from the program (or "lock out") providers delivering excessive service or poor quality care. In addition, states were allowed to seek waivers from HCFA of freedom of choice and other requirements to establish organized delivery systems--e.g., primary care networks or case management systems. Use of organized systems was further encouraged by legislative changes facilitating HMO enrollment for Medicaid beneficiaries.

Finally, in long-term care, states were allowed to seek waivers (of statewideness and other requirements) to establish home- and community-based service programs, as long as program costs under the new program did not exceed estimated program costs in its absence.

Beyond OBRA, two other actions promoted new types of policy. TEFRA allowed states to impose cost sharing on groups and services where it had previously been prohibited. And HCFA administrative policy allowed states greater freedom to seek family contributions to finance long-term care.

As noted at the outset, these new flexibilities (with the important exception of eligibility changes) allowed states to pursue cost containment through program efficiencies rather than simple benefit reductions.

Did these new options make a difference to the way states pursued cost containment in 1982?

The timing of states' responses to new opportunities and analysis of several states' approaches to cost containment suggest that the answer is no. As described in Chapters IV through VI, most states did not adopt newly authorized policies until after 1982--too late to affect spending in that year. Furthermore, most new programs are relatively small. Policies, like hospital payment methods, that affected larger numbers of popple, were also adopted over several rather than a single year and had a limited effect in 1982.

Further insight on state policy choices comes from a comparison of a set of states that controlled costs in 1982 with a set of states that did not slow their Medicaid spending. The results of that comparison are reported in Joel Cohen, "Containing Medicaid Costs: Twelve States' Experience Between 1981 and 1982" (MPE Working Paper 7.1). Comparison states were selected from a set of 31 states with reliable data on eligibility and expenditures. Six states with relatively low growth rates in spending (California, Illinois, Maryland, North Carolina, Texas, and Wisconsin) were compared to six states with relatively high rates of increase in Medicaid spending (Colorado, Florida, Minnesota, Ohio, Pennsylvania, and Utah). Growth rates in total Medicaid expenditures ranged from -2.3 to 2.2 percent among the slow-growing states and from 10.2 to 19.8 percent among the fast-growing states. The study's premise is that a comparison of the policies employed by these two groups of states will reveal which policies were responsible for cost containment.

Conclusions from this type of analysis, however, must be treated as suggestive more than definitive. First, a simple comparison of extremes does not control for a variety of factors, independent of policy choices, that could affect expenditure outcomes. Second, states in each group looked sufficiently like states in the other group on one or more characteristics (e.g., rate of increase in hospital spending) to make it difficult to identify the specific features of cost containers' success. Third, it is difficult to use reported data on policies as definitive characterizations of states' actual behavior. Policies described similarly (e.g., hospital rate controls, utilization controls) may be very different in design and operation. Finally, the states examined pursued such different mixes of policies--even within each groups--that it is difficult to clearly identify the specific policy instruments that made cost containers successful.

Recognizing these caveats, how did states that controlled Medicaid spending differ from states that did not?

First, consistent with analysis reported above, the two sets of states differed very little with respect to changes affecting the number of enrollees. Almost all states in both groups showed declines in enrollees of roughly similar magnitude. In contrast, states with small spending increases

averaged a 5.9 percent increase in spending per enrollee, compared to 19.4 percent for states with large increases. Differences between the two groups' rates of spending, then, reflected differences in control of spending per enrollee rather than the number of enrollees.

Second, states that controlled their Medicaid spending reported adoption of a far greater number of cost containing policies than did states with rapid spending growth. As a group, the six states with slow growth adopted 75 cost containing policy changes, with four of the six adopting more than ten policies each. In contrast, the six rapidly growing states adopted only 39 changes, with only one state adopting as many as ten.

Third, institutional cost containment appeared to be a necessity in containing total costs. Although states that contained costs differed in the kinds of institutions whose costs they controlled (some effectively controlled hospital spending; others, ICF/MRs or nursing homes), all demonstrated greater constraint in the aggregate for institutions than did states with rapid rates of growth.

Fourth, states' control of hospital spending involved both rate control and controls on service use--a combination of policies employed by most cost containing states. Rate controls without use controls appeared ineffective. In contast, some states controlled their hospital spending without rate reductions, apparently able to rely on use controls alone.

What can we infer from these patterns about states use of new versus old policy authority?

Overall, the differences between cost containers and spenders appear to be aggressive use of cost containment policies available prior to OBRA (primarily utilization and payment controls), rather than policies newly authorized by the 1981 law. In the institutional area, OBRA could have affected nursing home and ICF/MR spending through waivers for home- and community-based care. However, few of these programs were operated in 1982, most were small and successful cost containers were not more likely as a group to slow long-term care costs or to adopt waivers than were states with high rates of growth. While aggressive cost containment did seem to involve newly authorized hospital cost control, success was at least if not more dependent on utilization controls, allowable right along.

While not the key factor in their success, new flexibilities were nevertheless a part of the actions taken by cost-containing states. Among their efforts to control service use, cost containers were more likely to adopt copayments and restrictions on freedom of choice than were states that did not successfully control costs.

Cost containers' heavy reliance on pre-OBRA policies to contain costs suggests that OBRA did not fundamentally alter their approach to cost containment in 1982. Just as states responded primarily to their own fiscal pressures rather than changes in federal payment incentives (see above), they pursued their own routes to expenditure control.

How did states respond to specific new policy options?

States' autonomy is also apparent from their varied responses to OBRA's new provisions. Some new authority was hardly used. Only one state (Nevada) took advantage of new freedom of choice rules allowing volume purchasing of laboratory services; only four states took advantage of new authority to drop categories of the medically needy (three in very minor ways); only six states cut back the number of services offered the medically needy and only two of the 34 states that had AFDC provisions for first-time pregnant women failed to extend Medicaid eligibility to first-time pregnant women for which OBRA limited AFDC cash benefits.

At the other extreme, all states were forced to adjust their eligibility standards to comply with OBRA resource rules and to lower their age limits for AFDC children from 21 to 19. On the optional side, 45 states took advantage of new provisions to apply more stingent rules on transfer of assets; 48 states applied for community- and home-based care waivers; and 32 of 36 affected states took advantage of OBRA's option to eliminate coverage for 18 to 21 year-olds who would have been eligible for AFDC if under age 18 or in school.

For most of OBRA's other options, state responses fell between the extremes. On eligibility, 18 states lowered age limits for low-income children in intact families (Ribicoff children); and 11 states began to serve certain disabled children at home. Interestingly, some flexibility was apparent even when benefit changes appeared mandatory--i.e., with respect to the ceiling on gross income (at 150 percent of the AFDC need standard) for AFDC eligibility. Sixteen states mitigated the impact of that restriction for cash assistance and Medicaid by dramatically increasing their AFDC need standard.*

Most of OBRA's delivery changes were authorized by changes in freedom-of-choice requirements. In the most innovative area—primary care case management--13 states had received waivers for this purpose and were implementing programs as of August 1984. In other areas, however, OBRA's changes did not generate as much new activity as might have been expected. As noted above, only one state (Nevada) took advantage of new volume purchasing authority for laboratory services. However, volume purchasing arrangements for eyeglasses and hearing aids, allowed before OBRA was enacted, expanded in the 1981-1983 period--from 8 to 16 states. Similarly, lock-in programs, first formally authorized by OBRA, pre-existed that legislation in 28 states. Only nine states added programs after OBRA's enactment.

In hospital payment--the only provider payment method affected by OBRA--a similar pattern appears. Of 33 states with OBRA-authorized prospective payment systems in effect as of October 1984, 14 pre-dated OBRA's enactment.

---

*Payment standards, often well below need standards, determine welfare benefits. Hence, this action does not expand the number of persons receiving welfare benefits, but does prevent dropping some from the rolls.

Six of the new systems were adopted in the year after OBRA's enactment; another 13 in the following year, following Medicare's adoption of prospective payment.

This pattern suggests that changes in federal policy may be stimulators more than initiators of change. Not surprisingly, OBRA's new authorities reflected, to a large extent, policies that some states had already adopted.* OBRA's major role may have been to offer visibility and legitimacy to certain policy options, encouraging more cautious states to follow the leaders in the field.

---

*This point can also be argued for long-term care, where a few States used Medicaid's personal care option to provide many of the services allowed under the Section 2176 waiver.

III. ELIGIBILITY

The 1981 Omnibus Budget Reconciliation Act made a number of very important changes in Medicaid eligibility policy. This chapter begins by reviewing OBRA and other legislative changes and describing how states responded and actually altered eligibility for Medicaid. The effects of states' policy changes are then explored--first by looking at how policy changes have altered the Medicaid population and second by examining what happended to the population no longer able to qualify for Medicaid protection.

Who is eligible for Medicaid coverage?

As background to assessing OBRA's changes, it is useful to understand Medicaid's basic eligibility rules. Federal law requires states to cover some eligibles, called "categorically eligible"--those who receive welfare cash assistance. These include individuals receiving aid through the Aid to Families with Dependent Children and, in most cases, the Supplemental Security Income programs. Coverage of AFDC recipients is automatic but states have considerable discretion over income and resource standards. SSI is a Federal program with minimum income standards for cash assistance to the aged, blind, and disabled. In all but fourteen states, SSI recipients are automatically eligible for Medicaid.

In addition to people receiving cash assistance, states may also choose to cover people eligible for but not receiving cash welfare assistance and individuals eligible but institutionalized--the "optionally categorically eligible."

States may also make eligible for Medicaid persons whose incomes or assets are too high to allow them to receive welfare payments but who still are deemed unable to afford their medical bills--the "medically needy." Medically needy coverage allows people to "spend down" their incomes by incurring medical bills sufficient to reduce their income to welfare levels or a specified percentage above those levels. These levels cannot exceed 133 percent of the AFDC payment standard. As of June 1982, 30 states covered the medically needy.

How did OBRA change Medicaid eligibility rules?*

First, OBRA made two important changes in AFDC (and, thereby, Medicaid) eligibility affecting the working poor. Under OBRA, families with gross income (total income before any disregards) over 150 percent of a state's AFDC need standard were made automatically ineligible for AFDC and therefore for Medicaid benefits. Second, OBRA restructured the so-called "earned income disregards." Before OBRA, all expenses related to work, such as cost of child care, could be disregarded from income when benefits were calculated. In

---

*This discussion summarizes material presented in Ian Todd Hill, "Medicaid Eligibility: A Descriptive Report of OBRA, TEFRA, and DEFRA Provisions, and State Responses," MPE Working Paper 5.2.

addition, a work incentive disregard of $30 plus one-third of gross income could be subtracted as well. OBRA limited all of these disregards, changed the method by which they were calculated, and limited the period the work incentive disregard could be in effect. The effect was to increase countable income, eliminate some individuals from the assistance rolls, and reduce AFDC payments for others. Although applicable through 1984, these OBRA provisions were largely offset by the Deficit Reduction Act of 1984, which liberalized Medicaid (only) eligibility rules for AFDC recipients who go to work.

In addition to these income restrictions, OBRA also created limits on assets for AFDC families that applied uniformly to all states. Under the new legislation, families could possess a home of any value, an automobile worth up to $1,500, and other real and personal property considered essential up to a value of $1,000.

OBRA made four other mandatory changes in AFDC eligibility that potentially affected Medicaid:

(1) OBRA required that step-parent income--previously ignored--be counted in determining eligibility.

(2) OBRA altered AFDC eligibility for families with unemployed parents by limiting it to families whose "principal earner" was unemployed. The change clarified program intent that the dependent child must be deprived of the support of the family's primary earner, not just the support of one of two working parents.

(3) OBRA changed policy regarding first-time pregnant women with no other children. Prior to OBRA, states had the option of providing AFDC, and thus Medicaid coverage, to pregnant women with no other children. This coverage could begin as soon as pregnancy was medically verified or at some later point during pregnancy. OBRA limited this option by forbidding any cash payments until the sixth month of pregnancy. But states still have the option of providing Medicaid-only coverage to these women from the point of medical verification. Only AFDC eligibility is restricted under OBRA.

(4) Before OBRA, children in AFDC families could, as a state option, remain eligible for cash benefits between the ages of 18 to 21. OBRA limited this option by stating that only children under 19 years of age could retain eligibility for cash benefits and then only if they were attending a secondary or vocational school full-time and expected to complete their program before reaching the age of 19. College attendance was no longer an allowable reason for retaining eligibility.

OBRA also made optional coverage that was previously mandatory. Prior to 1981, all states had to extend Medicaid coverage to individuals 18 to 21 years

old who would have been eligible for AFDC if they were under 18 or in school. OBRA made this coverage optional and allowed states to limit coverage to children under 21, 20, 19 or 18. OBRA gave states similar flexibility to set age limits for eligibility in states choosing to provide Medicaid coverage to poor children in two parent families (Ribicoff children).

OBRA also contained important provisions affecting eligibility the medically needy. OBRA changed requirements that states provide coverage to all medically needy groups if they cover any one group; that all services provided to all medically needy groups be comparable in amount, duration, and scope; that a minimum number of services be provided to the medically needy; and the states offer a mix of institutional and noninstitutional care services. Under OBRA, states providing care to any medically needy group were told that they must also provide ambulatory services to children and prenatal and delivery services to pregnant women. In addition, if a state chooses to provide institutional services to any medically needy group, it must provide ambulatory services to the same group.

OBRA contained no major provisions affecting eligibility for the aged, blind and disabled.* However, TEFRA added one important provision that allowed states the option of denying Medicaid eligibility to persons who dispose of their home in order to qualify for benefits. TEFRA also made coverage of home care services for certain disabled children optional for states. The provision provided states with the option of covering under Medicaid certain disabled children under age 18 who live at home. (See Chapter VII.)

Finally, in addition to softening some of OBRA's AFDC eligibility restrictions, DEFRA required all states to extend Medicaid coverage to the following groups previously covered at states' choice: first time pregnant women who would be eligible for AFDC after the child was born; pregnant women in two parent families when the principal earner is unemployed; and all children born on or after October 1, 1983 up to age five in low income two parent families.

How did states respond to OBRA and other eligibility changes?**

Gross income limits. Although most states allowed OBRA's limit on gross income to cap Medicaid eligibility, several states increased their "need" standard to offset OBRA's gross income limit. At the same time, they kept their payment standard--which actually determined cash benefits--relatively stable, and thereby avoided an increase in welfare liability.

---

*An exception is the broader eligibility allowed under Section 2176 waivers for in-home and community-based care. See Chapter VI.

**This discussion summarizes material presented in Ian Todd Hill, "Medicaid Eligibility: A Descriptive Report of OBRA, TEFRA, and DEFRA Provisions, and State Responses," MPE Working Paper 5.2.

Sixteen states raised need standards dramatically between 1981 and 1983, while keeping payment standards relatively stable. In 1981, nine states raised their need standards: Alabama (100%), North Carolina (100%), Georgia (90%), Montana (61%), Idaho (50%), Illinois (40%), Colorado (31%), Alaska (27%) and Ohio (21%). These states raised their payment standards an average of only 9 percent. In 1982, six more states substantially increased their need standards: Florida (98%), Pennsylvania (72%), Washington (55%), the District of Columbia (49%), Maryland (38%), and Mississippi (30%). The growth in payment standards for these six states averaged less than 4 percent. In 1983, Texas raised its need standard by 248 percent. At the same time, it increased its payment standard by only 49 percent. The fact that the need standards were increased in these states by amounts that far exceeded their payment standards increases is an indication that they were primarily concerned with keeping families with earned income on the AFDC rolls and eligible for Medicaid. If their primary concern had been to increase cash assistance, the payment standards would have increased at comparable rates.

Resource and asset limits. In eleven states, OBRA's allowance of a home of any value represented a liberalization of asset limits. A limit of $1,500 on the value of an automobile represented a tightening of standards for 41 states, whereas in 4 states this provision represented a more generous policy. A $1,000 per family limit on other personal and non-home real property resulted in 28 states becoming more restrictive. Nine states became less restrictive.

Eligibility limit for first-time pregnant women. At the time OBRA was legislated, 34 states extended AFDC cash eligibility to first-time pregnant women. While this rule change had severe effects on cash eligibility, it seems to have had a much smaller effect on Medicaid. This is because the vast majority of states with AFDC provisions for first-time pregnant women also chose to provide Medicaid coverage to such women who would be eligible for AFDC once the child was born. All but an estimated 2.6 percent of the potentially affected adults were therefore left unaffected in terms of their Medicaid coverage.

Age limits for AFDC children in school. Prior to OBRA, 36 states extended AFDC cash benefits to children between the ages of 18 and 21 who were attending school. OBRA required all these states to reduce the age of coverage to 19, removing an estimated 200,000 young adults from the program.

Optional coverage for children 18 to 20. In response to OBRA, 32 states eliminated this group entirely from Medicaid coverage, affecting an estimated 10,000-11,000 young adults. Four other states maintained coverage but set new age limits. Fourteen states covering all Ribicoff children under age 21 were not affected by this provision.

Medically needy changes. Since OBRA, very few states have narrowed their medically needy programs. Tennessee dropped all coverage for the newly optional groups of the aged, blind, disabled, and caretaker relatives. Between 1982 and 1983, only six states reduced the number of optional services they provided to the medically needy. However, during the same period, 10 states increased their service provision by adding additional types of

services. OBRA seems to have created an incentive for states to add limited medically needy programs to their state Medicaid plans. Several states have either implemented or plan to soon implement limited medically needy programs to serve pregnant women and children.

Age limits for Ribicoff children. Eighteen states took advantage of OBRA's flexibility to set age limits below age 21 for Ribicoff children.

Transfer of assets (TEFRA). Since 1982, 45 states have adopted TEFRA's option to deny Medicaid eligibility to persons who dispose of their home solely to qualify for Medicaid benefits.

Required Medicaid coverage for pregnant women and children (DEFRA). Only seven states did not previously cover first-time pregnant women who would become eligible for Medicaid once the child were born. These seven states will be forced to add coverage.

Twenty-one states were forced to add coverage for pregnant women in two-parent families where the principal earner is unemployed. Mandatory coverage for all financially-eligible children under 5 will affect 28 states.

How many people lost eligibility due to OBRA's provisions?

Aside from the estimates developed by Hill, studies undertaken by the Medicaid Program Evaluation did not directly address the question. This is a difficult question to answer, because factors other than OBRA--most importantly the recession--affected the number of persons eligible.

Two other studies, however, have estimated the OBRA affect, attempting to control for the effects of the recession The General Accounting Office,* using a forecasting method not fully described in their report, found that after controlling for unemployment, there was a 13.7 percent drop in AFDC eligibility due to OBRA. They estimated that there were 493,000 fewer cases, e.g., families, opened in an average month. This was from a base of 3.6 million cases in September of 1981.

Cromwell** also estimated the effect of OBRA after controlling for other influences using a dynamic quarterly first difference model. In performing a simulation of the effects of OBRA and other factors over 1981-1982, Cromwell found that unemployment would have increased the rolls by 5.6 percent, or one million enrollees, increases in population by 1.8 percent, and various other factors by .5 percent. Offsetting this was the effect of OBRA which apparently reduced enrollment by 13.4 percent, or 2.3 million persons. The net effect should have been a reduction between 1981 and 1982 of 5.4 percent, once

---

*General Accounting Office, "An Evaluation of the 1981 AFDC Changes: Initial Analysis," April 2, 1984.

**Jerry Cromwell et al., "The Evolution of State Medicaid Programs," Center for Health Economics Research, June 1984.

lagged unemployment effects are realized in early 1983. SSI-cash enrollee effects were minimal. Nearly two million of the OBRA disenrolled AFDC-cash enrolles had an 18 percent decline while the rest were non cash medically needy.

This total estimate comes very close to the actual changes in number of eligibles reported in Chapter I. To examine eligibility before and after OBRA, Joel Cohen and John Holahan ("Medicaid Eligibility After the Omnibus Budget Reconciliation Act of 1981," MPE Working Paper 5.1) used monthly HCFA data available for each month from October 1980 through September 1982 to compute the monthly average number of persons certified as eligible for Medicaid for each of 8 different eligibility classifications in 31 states. Thirty-one states were selected after a careful examination of the data to assure intra-period validity over the time period of interest. Eligibility classifications were divided into the aged, blind and disabled, AFDC children, and AFDC adults, both receiving cash assistance and not receiving cash assistance. An analysis was done by disaggregating states into those with and without medically needy programs and those with and without AFDC-UP programs. The results showed that for the 31 states there was a reduction of 4.7 percent in total enrollment between 1981 and 1982, reasonably close to Cromwell's estimate of 5.4 percent. For eligibles receiving cash assistance, there was a 5.2 percent reduction; for eligibles not receiving cash assistance, there was a reduction of 1.4 percent.

The reductions were distributed among eligibility groups in the following ways: aged receiving cash assistance, 5.9 percent; blind and disabled receiving cash assistance, 0.9 percent; AFDC children receiving cash assistance, 7.3 percent; and AFDC adults receiving cash assistance, 3.2 percent. For those not receiving cash assistance, the aged fell by 2.3 percent; the blind and disabled by 5.3 percent; and the AFDC children by 2.5 percent. In contrast to other groups, AFDC adults not receiving cash assistance actually increased by 9.2 percent.

The study also showed that the average monthly number of Medicaid eligibles declined in 28 of the 31 states examined. As noted, the largest declines were in AFDC eligibility categories, consistent with the changes in AFDC eligibility mandated by OBRA.

How much did OBRA's eligibility changes affect Medicaid expenditures?

This is a difficult question to answer for two reasons. First, individuals losing eligibility under Medicaid are quite likely to use fewer services, on average, than people remaining on the rolls. To begin with, Medicaid eligibles losing eligibility are largely from the AFDC population which is the lowest utilizing group in the program. And, those losing eligibility are the working poor. These individuals are likely to be healthier and have a higher opportunity cost of time than the non-working poor on Medicaid. For both reasons they are likely to use fewer services. In addition, the working poor who lost eligibility are more likely to have had private insurance. (See below.) It is therefore possible that states were collecting from other third-party payers for some of the expenses borne or incurred by those individuals who lost Medicaid coverage.

While difficult to estimate with precision, one can make a reasonable estimate of the direct impact. GAO, for example, estimated that Medicaid expenditures fell by $93 million per month, or $1.1 billion per year. Stephen Long and Russell Settle used multivariate analysis to estimate spending reductions due to eligibility changes. Their approach recognizes that the people dropped from Medicaid rolls were somewhat healthier than those retaining eligibility and consequently used fewer of most health services than those retaining eligibility. They estimate that adults exiting the Medicaid rolls as a result of OBRA would have used, on average, 98.1 percent of inpatient hospital services, 93.4 percent of physician services, 93.6 percent of drug purchases, and 103.4 percent of dental services. Corresponding numbers for AFDC children were 89.9 percent for inpatient hospital services, 97.7 percent for physician services, 97.9 percent for prescription drugs, and 109.3 percent for dental services. Based on these estimates of Medicaid service use, Long and Settle estimate that dropping these people from the Medicaid rolls produced annual cost savings of $926.4 million.

How did eligibility reductions affect the working poor?

As noted above, several of OBRA's eligibility changes were directed at the working poor--welfare or Medicaid recipients who earned some income. To understand how, in fact, the eligibility changes affected this population, two types of studies were undertaken: (1) an analysis of changes in the Medicaid population, to indicate the kinds of people OBRA actually eliminated from the rolls; and (2) an analysis of what happened to people who lost their eligibility.

To determine who lost eligibility, Stephen H. Long and Russell F. Settle analyzed how OBRA's eligibility changes altered the characteristics of the Medicaid population ("The Impact of Eligibility Changes Under the Omnibus Budget Reconciliation Act of 1981 on the Characteristics of the Medicaid Population," MPE Working Paper 5.3). In order to control for the recession and other factors affecting the Medicaid population (most notably, the payment standards states set to determine eligibility), their study compared the incomes and earnings of the working AFDC-Medicaid population before and after OBRA went into effect to the income and earnings of a control group of low-income persons not eligible for Medicaid in either period. Their study found the following: Between 1981 and 1982 mean incomes (measured in constant 1979 dollars) fell for all AFDC Medicaid eligibles (working and nonworking) and for the low-income noneligibles. For Medicaid eligibles not working and for low income noneligibles, the decline continued a trend that preceded OBRA. But working Medicaid eligibles experienced a larger drop in 1982, departing significantly from the previous trend.

For nonworking Medicaid eligibles, mean family income (in constant 1979 dollars) fell 6 percent between 1981 and 1982, presumably because of real declines in states' payment standards. For low income noneligibles, income fell 2 percent, presumably due to the recession. In contrast, the working Medicaid population experienced an income decline of 12 percent. Almost all

the 10 point difference between eligible and ineligible workers is a function of OBRA's having eliminated higher income workers from the Medicaid rolls.*

Not surprisingly, OBRA had an even greater impact on earnings. While mean earnings (in 1979 constant dollars) for the low income control group dropped about 2 percent after OBRA, earnings for working Medicaid eligibles fell 16 percent. Again, the difference reflects OBRA's elimination of the higher earners.

It seems, then, that OBRA had the expected effect of removing the higher earning working poor from the Medicaid program. Further evidence of this effect is the fact that the proportion of the working Medicaid population that fell into the poor/near-poor category rose from about 73 to 80 percent between 1981 and 1982.

How did OBRA's eligibility cut affect work effort among the working poor?

A longstanding concern about reducing benefits to low income people who work is that they will cut back their work effort to avoid losing benefits. Did OBRA's cutbacks for the working poor discourage work? A comparison of labor force participation before and after OBRA's adoption suggests that the answer is yes.

Long and Settle compared changes in the employment rates and hours worked for the working AFDC-Medicaid population, before and after OBRA, to changes experienced by a similar low income noneligible population. As above, the comparison group is used to distinguish effects of OBRA from the recession's effect. Between March 1981 and March 1982 (the dates of the Current Population Survey on which the analysis is based), the employment rate of heads of working Medicaid families declined from 59 to 52 percent--6 percentage points greater than the decline in employment rate among the control group. Similarly, between 1981 and 1982 annual weeks worked by employed heads declined by 9.8 percent among working Medicaid families, compared to a drop of 1.4 percent for low income noneligibles, and annual earnings (in constant 1979 dollars) of employed heads of Medicaid families fell 11.9 percent, but remained stable for the noneligible population.

The fact that work and earnings declined more for the working Medicaid population than for a similar control group suggests that something other than the recession affected work levels, notably OBRA. The drop was not, however, a reflection of OBRA's impact or the composition of the Medicaid population, that is, of workers having left the rolls. That is because the people whom OBRA eliminated from the rolls in the fourth continue to be identified in March 1982 survey as "on Medicaid" in 1981, along with people still on Medicaid in March 1982. Hence, the decline in work and earnings associated with OBRA appears to reflect some use reduction in work effort by people who were on Medicaid during 1981.

---

*Working Medicaid eligibles' incomes were hardly affected by declines in AFDC payment standards, since their cash benefits are very low.

Since this survey cannot distinguish between people who lost Medicaid coverage before March 1982 and people still on at that time, it does not tell us whether people worked less to avoid losing Medicaid benefits or to regain benefits lost. Other studies, however, have found little or no evidence of decline in work effort among people who lost Medicaid eligibility.

Moscovice and Craig,* for example, examined a sample of 542 family heads terminated in January 1982. He examined their employment status as of January 1983 and found that 67.2 percent were off of AFDC and working, 5.2 percent were off of AFDC and not working, 11.8 percent were on AFDC and working, 15.9 percent were on AFDC and not working. Those who were working, both those off of AFDC and on AFDC, increased weekly hours worked, the pay rates, and the likelihood of having a second job. Moscovice concluded that the increase in labor force participation overshadowed the minority of respondents who either quit work or reduced hours to remain eligible. The reduction in labor force participation that he did observe, he believes could have been attributed to the recession more than to OBRA.

Similarly, GAO** found that only 7 to 18 percent, depending on the site, of those who originally lost AFDC eligibility had returned to the rolls 12 months later. In Boston, Milwaukee, and Syracuse 77 to 88 percent of the sample populations were gainfully employed after losing AFDC eligibility. In Dallas and Memphis, the percentages were 63 and 69, respectively. A survey done by the Research Triangle Institute found that only 8 percent of those determined ineligibile because of OBRA had returned to AFDC at a later date. Eighty-seven percent of their sample was working.***

In light of the evidence, the reduced work effort identified in the comparisons reported above would seem to reflect the behavior of people still on Medicaid, seeking to avoid being cut off.

What happened to people who lost their Medicaid eligibility?

Perhaps the most important question in assessing the impact of policy change is finding out what happened to people that OBRA removed from the Medicaid rolls. Three dimensions of their experience can be examined--income, health insurance and use of health services.

Income: GAO reported that earners losing eligibility for AFDC suffered AFDC cash assistance losses of from $71-$74 per month in Dallas and Memphis,

---

*Ira Moscovice and William Craig, "The Impacts of Federal Cutbacks on Working AFDC Recipients in Minnesota," unpublished paper, December 1983.

**General Accounting Office, 1984.

***Research Triangle Institute, "Final Report: Evaluation of the 1981 Amendments," April 15, 1983.

and from $156-$198 in Boston, Milwaukee, and Syracuse.* Earners receiving reduced benefits experienced losses of from $46-$52 in Dallas and Memphis, and from $110-$137 in Milwaukee and Syracuse (data on Boston were unavailable). GAO also cited evidence of loss of Food Stamp benefits for a large percentage of individuals losing AFDC. The GAO compared total monthly earned and unearned income before and after OBRA. In spite of the fact that workers increased earnings in many cases, individuals' total monthly income after OBRA was from $115 to $229 per month less than before OBRA was enacted.

Moscovice and Craig also found declines in the economic status of the individuals of 542 families who lost eligibility in Hennepin County, Minnesota.** People who stayed off AFDC and worked (67.2%) had increased net earnings from work that had replaced only one-half of their previous unearned income. People who got back on AFDC and worked (11.8%) did not appear to suffer overall income losses. People who got back on AFDC and did not work (15.9%) had increases in unearned income roughly equivalent to their losses of earnings.

Health Insurance: Long and Settle found that, among those families rendered ineligible for Medicaid by OBRA, approximately one-half were successful in replacing Medicaid with group health insurance. The remaining one-half of these families were left with no insurance coverage at all.

Other studies have also found substantial numbers without insurance. Moscovice reported that approximately 25 percent of those off of AFDC and working and approximately one-third of their children did not have health insurance coverage in January 1983, a year after termination.*** Only 1 percent of this group bought private health insurance directly, presumably due to cost. Those that had private health insurance through work had considerably weaker coverage than those still on Medicaid. He found that those off of Medicaid and working paid over half of their health care bills out of pocket and reported delaying seeing physicians and dentists significantly more often than those who remained on AFDC.

GAO reported that terminated Medicaid recipients obtained private insurance in only 25 percent of the cases in Dallas and Memphis and between 57 percent and 67 percent of the cases in Boston, Milwaukee, and Syracuse.**** Sixty percent of the respondents in Dallas had no coverage at all for themselves or their children, while in Memphis 60 percent of the parents and 50 percent of their children had no health coverage whatsoever.

---

*General Accounting Office, 1984.

**Moscovice & Craig. 1983.

***Ibid.

****General Accounting Office, 1984.

Use of Health Services: Long and Settle addressed the question of reduced access due to loss of Medicaid coverage by using the 1980 National Medical Care Utilization and Expenditure Survey (NMCUES) and the 1982 Current Population Survey (CPS). (See "Cutbacks in Medicaid Eligibility under the Omnibus Budget Reconciliation Act of 1981: Implications for Access to Health Care Services Among the Newly Ineligible", MPE Working Paper 5.4.) Their analysis used the information from NMCUES to estimate how insurance coverage and other individual characteristics affect peoples' use of health services. The insurance and demographic characteristics of the population OBRA made ineligible were identified using the CPS. The CPS information on newly ineligibles' characteristics was combined with the coefficients from NMCUES utilization equations to estimate newly ineligibles' use of health services.

Estimates were made for the 55 percent of the newly ineligibles who lost Medicaid, but acquired private insurance, and for the 45 percent who lost Medicaid and had no coverage at all. Individuals who lost Medicaid coverage but acquired private insurance were estimated as likely to experience statistically insignificant decline in the use of ambulatory physician services, inpatient hospital services, and prescription drugs. In contrast, the 45 percent of the newly ineligible population that did not acquire insurance coverage were estimated as likely to experience large, statistically significant declines in their use of these health services.

Long and Settle estimate that the loss of Medicaid eligibility due to OBRA would, over time, lower their use of physician services by 38 percent, use of inpatient hospital services by 71 percent, and purchase of prescription drugs by 39 percent. Loss of coverage for dental services was estimated as resulting in a 61 percent reduction in the use of those services. Because 92 percent of those losing Medicaid were estimated to have acquired no dental coverage, the effect of a large reduction in use applied to virtually the entire newly eligible population.

These estimates of substantial drops in utilization depend on the Medicaid coverage variable truly capturing an insurance effect, that is, a behavioral response to lower out-of-pocket prices. If in fact the Medicaid population is really different in, for example, its health status or racial characteristics, then part of the large effect on utilization may be capturing population characteristics that are not controlled for in the regression. There is some possibility that these effects are, therefore, overstated. Because the implementation of the OBRA legislation placed severe constraints on research design, there is little that could have been done to solve this problem. Similarly, if non-financial barriers differ between Medicaid and non-Medicaid populations some of the utilization effect may be inappropriately attributed to Medicaid coverage.

IV. HOSPITAL REIMBURSEMENT

The 1981 OBRA legislation gave states greater flexibility and authority over their hospital payment methods. Specifically, it made it easier for states to adopt alternatives to Medicare's retrospective cost-based principles of hospital reimbursement. Further stimulus to policy change came from reform in Medicare reimbursement policy itself, first in TEFRA legislation and then in legislation that established the Medicare prospective payment system (PPS).

This chapter summarizes research that examines Medicaid policies toward hospital payment since OBRA's enactment. How have states changed their payment systems? How have alternative payment systems affected Medicaid hospital spending? And what can be learned from new systems' implementation?

How have states altered their Medicaid hospital payment systems?

OBRA clearly promoted the adoption of new payment systems. (See Larry Beyna and John Trutko," Exploring the Effect of PPS on Medicaid," MPE Working Paper 8.1). In April of 1982, before OBRA's enactment 14 states used prospective payment. By June of 1983, 20 states had these systems and 33 were operating by October of 1984. There are several reasons for these changes. The most important was the severe budget crisis encountered by states during the early 1980s. Changes in the Medicare system--first by TEFRA, then by PPS--were also an important impetus for state changes. The increasing flexibility granted by OBRA was probably less of a cause for these changes than it was a symptom of pressure which had been building for some time. In any event, the flexibility allowed by OBRA considerably eased the difficulties for states which wanted to replace retrospective cost-based reimbursement with other forms of hospital reimbursement.

A review of state payment systems makes clear that DRGs and even prospective payment are not the only policies worthy of attention. Holly Korda and Michael Koetting ("State Medicaid Inpatient Hospital Reimbursement: Summary of State Programs," MPE Working Paper 3.3) show that states have adopted a variety of payment systems and that controls can be imposed in retrospective as well as prospective systems. As of November 1984, prospective payment systems were in effect in 33 states. Prospective payment is defined as a system that establishes rate of payment in advance of the period for which payment applies and allows no reconciliation of payments to costs after the period ends. Retrospective systems are used by 18 state programs.*

---

*Korda and Koetting identified 32 prospective and 15 retrospective systems. However, Korda and Koetting do not classify Texas and have omitted Alaska and Hawaii. By including these states, Alaska as a prospective state and Hawaii and Texas as retrospective states (based on the Beyna and Trutko classification), we arrive at 33 prospective and 18 retrospective states, consistent with those of Beyna and Trutko. Note that this total reflects the fact that California has two systems in operation.

Table 9 summarizes the systems in place as of November, 1984. The table distinguishes between cost-based or reconciled systems and prospective or non-reconciled systems. Korda and Koetting emphasize that despite the widely and often cited differences in the incentive structures of retrospective and prospective systems, the true incentives are also dependent on the various limits and ceilings either kind of system employs. Limits are therefore included in Table 9 classification. Only eleven states employed retrospective cost reimbursement with no ceilings. The remainder using cost reimbursement limited costs by an inflation rate or a peer group ceiling and an inflation rate.

Korda and Koetting classified prospective systems into four categories: (1) base year costs trended forward (trended base), (2) trended base, limited by peer group ceilings (3) fixed, flat-rate, per-case methods, and (4) negotiated systems. The trended base systems use trend or inflation factors to establish a prospective reimbursement rate on a per diem or per admission basis. These arrangements have been implemented in 16 states. Some use the previous year's cost as the basis for reimbursement; others project reimbursement from a fixed base year.

Six states used the trended base with peer group method. New York is an example of a stringent peer group system. Implemented in conjunction with New York's all-payer program, peer group standards are based on geographic location, size, case mix, and service mix through set limits on base year costs. Reimbursements for each group are limited to the peer group average plus five percent.

Six states used flat rate or per-case reimbursement methods based on grouping systems such as diagnostic categories to establish hospital reimbursement. These systems are similar to the Medicare DRG system. Hospitals receive an average payment per case regardless of length of stay or service utilization. Outliers, or cases which exceed a defined upper limit or DRG category, are reimbursed on the charge or cost basis. New Jersey was the first state to adopt an alternative DRG type system as part of the demonstration program. Ohio, Pennsylvania, Utah, and Washington have all adopted DRG type reimbursement systems; Michigan, Oregon, and Connecticut are planning adoption. Nevada pays on the basis of flat rates for six different types of cases, with per diem payments for stays longer than 15 days.

Contracting and negotiated reimbursement systems are used in California, Washington, D.C., Rhode Island, and Vermont. Alaska, while having certain characteristics for more traditional prospective systems is also essentially a negotiated system. The California system receives greater discussion below. Illinois will attempt a "California-style" approach on a trial basis in early 1985.

How have alternative payment systems affected Medicaid hospital spending?

Jerry Cromwell and Sylvia Hurdle ("National Impact Study of Alternative Reimbursement Waivers," MPE Working Paper 3.2) addressed this question, examining data on rates of increase in hospital spending for 1979-1983 for the nation as a whole and for three distinct groups of states: (1) States using

Table 9

Medicaid Inpatient Hospital Reimbursement Method, by State

State	Reconciled			Non-Reconciled			
	Cost	Cost to Trend Limit	Cost to Peer and Trend Limit	Base Trended	Trended Base With Peer	Flat Rate by Group	Negotiated
Alabama				X			
Alaska							X
Arkansas					X		
California*			X				X
Colorado				X			
Connecticut			X				
Delaware	X						
Washington, DC							X
Florida				X			
Georgia				X			
Hawaii	X						
Idaho				X			
Illinois					X		
Indiana	X						
Iowa				X			
Kansas				X			
Kentucky					X		
Louisiana		X					
Maine				X			
Maryland				X			
Massachusetts				X			
Michigan			X				
Minnesota				X			
Mississippi					X		
Missouri		X					
Montana	X						
Nebraska				X			
Nevada						X	
New Hampshire	X						
New Jersey						X	
New Mexico		X					
New York					X		
North Carolina				X			
North Dakota	X						
Ohio						X	
Oklahoma				X			
Oregon				X			
Pennsylvania						X	
Rhode Island							X
South Carolina	X						
South Dakota	X						
Tennessee				X			
Texas	X						
Utah						X	
Vermont							X
Virginia					X		
Washington						X	
West Virginia	X						
Wisconsin		X					
Wyoming	X						

*Two systems in effect.

traditional Medicare cost reimbursement approaches throughout 1979-1983, termed control states; (2) States using alternative systems prior to OBRA's enactment in 1981; (3) States using alternative systems after 1981. In the latter group were included states which adopted alternative systems either in 1982 or in 1983. As the authors acknowledge, the analysis suffers from the difficulty of attributing changes in growth rates to these reimbursement systems when the systems may have been in place for a relatively short part of the post-OBRA period. They also point out that there are major variations in the methods and stringency of programs within each of the two study groups.

The comparison of growth rates in Medicaid hospital spending is reported in Table 10. As the table shows, annual rates of increase in national hospital spending were lower in 1981-1983 (10.0%) than they had been in 1979-1981 (12.2%). The two periods showed no difference in the rate of increase in spending per beneficiary.

This finding indicates that the dramatic slowdown that occurred in 1982 did not persist (consistent with analysis presented in Chapter I),* and that declines in recipients, rather than lower rates, are the primary factor explaining lower rates of increase in spending. Declines in recipients are a function of changes in eligibility, utilization controls, and rate reductions that may reduce hospitals' willingness to service Medicaid patients.

National data alone, however, cannot give a clear indication of what new payment systems have contributed to these results. National data give heavier weight to larger states and reflect a variety of factors, independent of payment systems. A clearer assessment of payment systems' effects can be made in two ways: 1) comparing rates of increase in states with and without alternative systems, before and after OBRA's change; and 2) using multivariate analysis that tries to hold constant an array of other factors affecting rates of increase.

A comparison of rates of increase in total Medicaid hospital expenses, before and after 1981, shows that all types of states experienced lower rates of increase after than before OBRA; but the largest drop in rate of increase and the lowest post-OBRA rate of increase occurred in states with alternative systems. (See Figure 5.) Rates of increase in pre and post OBRA alternative system states fell from 14.4 and 15.7 percent respectively to about 8.5 percent. In contrast, in states using Medicare payment methods, the rate of increase only fell from 16.7 to the still relatively high 12.7 percent.

This difference across the three groups of states in part reflects differences in experience with respect to recipients. Recipients fell in the states adopting alternative systems but grew in the Medicare reimbursement

---

*Cromwell's and Hurdle's analysis use 2082 expenditure data, which are reported annually by the state. Holahan's analysis, reported in Chapter I, uses data from HCFA form 64, a report on actual expenditures made by the federal government. Differences in the analysis reflect both differences in the data and differing methods used to adjust for anomalies in the data.

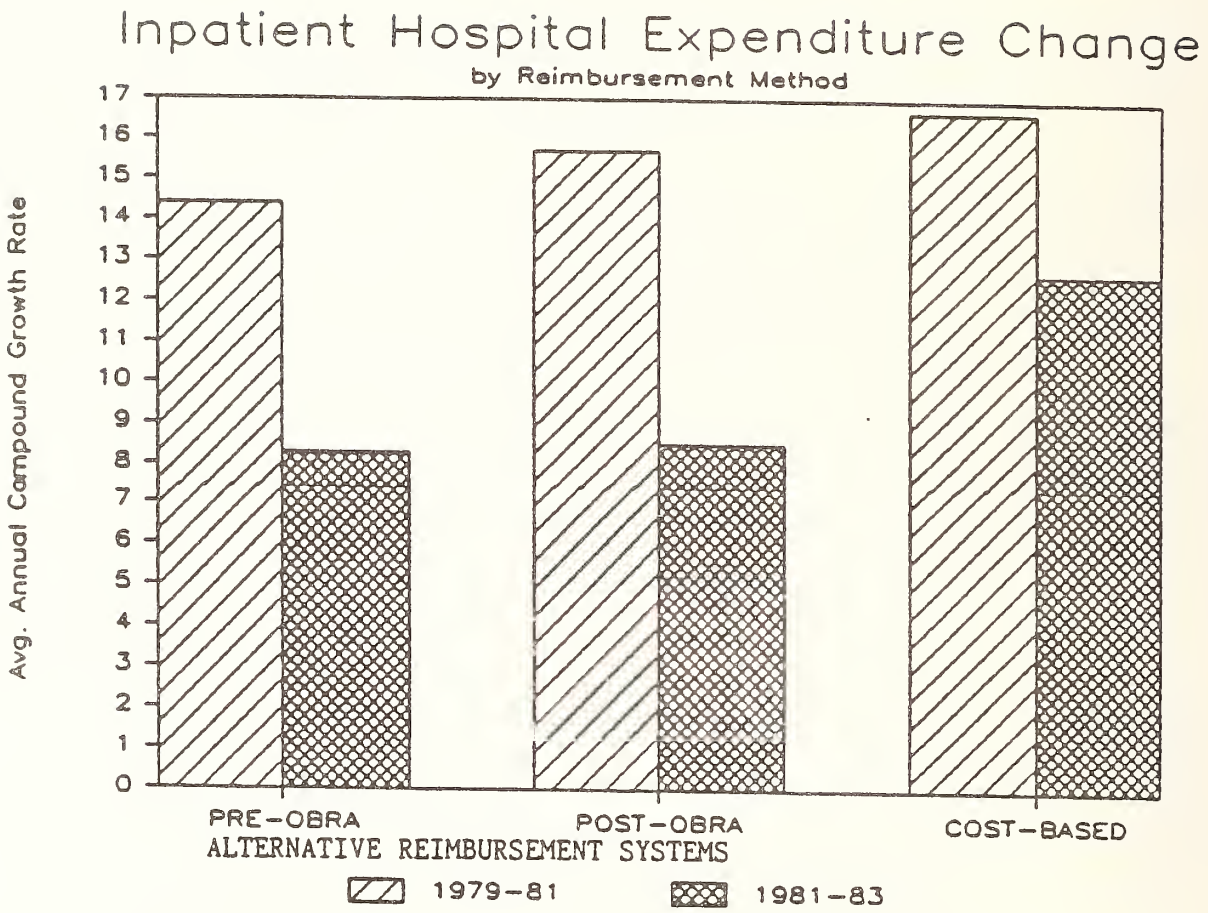
Table 10

Average Annual Growth in Medicaid Inpatient Hospital Expenditures for Pre- and Post-OBRA Periods, by Reimbursement System

	Expenditures		Expenditures Per Recipient		Recipients		Expenditures Per Enrollee		Enrollees	
	1979-1981	1981-1983	1979-1981	1981-1983	1979-1981	1981-1983	1979-1981	1981-1983	1979-1981	1981-1983
	Average Annual Compound Growth Rates in Hospital Expenditures									
Total U.S.*	12.2	10.0	10.6	10.5	1.4	-0.5	9.6	12.1	2.4	-1.9
Pre-OBRA Alternative System States	14.4	8.3	13.8	9.3	0.5	-1.0	11.8	11.1	2.3	-2.5
Post-OBRA Alternative System States	15.7	8.5	14.5	11.2	1.0	-2.4	12.9	11.6	2.5	-2.8
Medicare Reimbursement States	16.7	12.7	19.5	12.0	1.9	0.6	14.7	17.1	1.7	-3.8
	Average Annual Compound Growth Rates in Hospital Expenditures - AFDC									
Total U.S.*	8.9	7.6	6.8	8.9	2.1	-1.2				
Pre-OBRA Alternative System States	9.9	7.3	9.1	9.3	0.7	-2.0				
Post-OBRA Alternative System States	16.7	7.6	14.2	10.3	2.4	-2.7				
Medicare Reimbursement States	18.8	10.5	14.9	10.8	3.9	-0.0				
	Average Annual Compound Growth Rates in Hospital Expenditures - SSI									
Total U.S.*	18.1	12.2	15.0	12.1	3.1	0.2				
Pre-OBRA Alternative System States	17.6	8.1	18.6	10.1	-1.0	-2.1				
Post-OBRA Alternative System States	14.4	9.2	14.1	12.5	0.3	-3.3				
Medicare Reimbursement States	18.3	13.8	13.7	12.4	4.5	1.4				

*Averages for the U.S. were calculated from state data weighted for program size. Other data are unweighted.

Figure 5


Inpatient Hospital Expenditure Change
by Reimbursement Method
Avg. Annual Compound Growth Rate
17
16
15
14
13
12
11
10
9
8
7
6
5
4
3
2
1
0
PRE-OBRA
POST-OBRA
COST-BASED
ALTERNATIVE REIMBURSEMENT SYSTEMS
1979-81
1981-83

system states. The decline in recipients that occurs in the alternative system states but not in the control group states is of some interest. While it may be attributable to the decline in eligibility, it is of interest that recipients grew in the control states despite the largest decline in enrollment. There is some possibility that the decline in recipients in the alternative system states may reflect lower utilization which could be attributable to either rate setting or to stricter utilization controls. It may be, that is, that states adopting rate setting approaches were also adopting stronger direct controls on utilization.

An examination of changes in expenditures per recipient is also suggestive of some effect of rate-setting on spending. First, states with alternative systems experienced lower rates of increase before and after OBRA. Second, although all 3 groups of states experienced declines in expenditures per recipient after 1981, the pre-OBRA alternative states had much lower rates of increase in 1981-1983 than did other states.

Multivariate analysis of the effectiveness of pre and post-OBRA systems found that rate setting had a negative but not significant impact on rates of increase in spending. Weak findings for post-OBRA states are not surprising, since many of these systems were not adopted until the middle or end of the 1981-1983 period being examined.

What can be learned from the implementation of payment reform?

Because of its dramatic departure from traditional hospital payment methods, California was selected for an in-depth study of payment reform. This discussion of California's experience summarizes material presented in Michael Koetting and Lois Olinger, "Selective Contracting in California: The First Year," MPE Working Paper 3.1.

In response to a severe fiscal crisis, exacerbated by reductions in Federal Medicaid rates, in 1982 the California legislature undertook a major reform of California's Medicaid program (MediCal). Among the measures* taken was adoption of hospital contracting. Specifically, the California legislature authorized the Governor to appoint a "special negotiator" to negotiate contracts with hospitals for serving MediCal beneficiaries. The negotiator was to serve one year and was exempted from provisions of administrative law in performing his task. At the year's end, responsibility for managing contract systems was shifted to a 7-member commission.

California's implementation of hospital contracting was facilitated by OBRA's provisions promoting alternative hospital payment systems and allowing waivers of freedom-of-choice and other requirements. California submitted

---

*The two other most important measures were changes in MediCal's definition of "medical necessity," which limited service use, and the turning back of responsibility for the medically indigent (who had been incorporated in MediCal at state expense) to the counties.

waiver requests to HCFA in August 1982--two months after OBRA's enactment--and the program went into effect (with HCFA approval) in the winter of 1983.

What were the goals of the contracting system?

California's negotiator--William Guy--had a choice in designing the contracting system. To achieve the savings the legislature sought, he could contract primarily with low-cost hospitals, shifting Medicaid recipients to these institutions; or he could use contract bidding as a mechanism to get hospitals already serving MediCal beneficiaries to lower their rates. Guy took the latter approach, contracting with virtually all hospitals which had provided any significant MediCal coverage prior to contracting. Contracting hospitals had previously provided more than 85 percent of all hospital care to MediCal recipients. He accomplished this by threatening to exclude hospitals that bid too high (and--visibly but temporarily--excluding three major hospitals in San Francisco). This effectively forced almost all hospitals to forego inflation increases and actually lower their rates.

How did hospitals respond in the contracting process?

Despite widespread complaints about MediCal and its rates, most hospitals entered the bidding process. In the bidding that occurred up to May 1, 1983, only 11 percent of the eligible hospitals did not submit bids. According to interviews, some of the bidding hospitals were not bidding seriously but were merely going through the motions for public relations or to avoid later Certificate of Need difficulties. General evidence for the questionable sincerity in some contractual efforts can be seen in the fact that, as a group, non-contracting hospitals were restricting the amount of MediCal services they provided prior to the onset of contracting. State data show that between July 1980 and August 1982, MediCal users (excluding the state-financial medically indigent) declined by 3 percent in hospitals which later received contracts, but declined by 25 percent in hospitals which became non-contractig hospitals. Thus, even before the onset of contracting, these hospitals were reducing the amount of relative MediCal coverage being provided.

The most common theme expressed by hospitals in explaining why they ultimately bid was their desire to protect their current MediCal business, largely to protect the share of income associated with MediCal. Few hospitals could afford to lose 8, 10, 12 or more percent of their revenue at one fell swoop. The economics compelled hospitals to consider reductions in MediCal revenue in order to avoid losing it all. Other factors reinforcing a decision to bid included a desire to retain physicians who served MediCal as well as other patients, preserving the hospital's historic role, protecting teaching activities, and satisfying bond rating agency requirements, which made a MediCal contract a prerequisite for rating.

Very few hospitals showed interest in expanding their MediCal share. Hospitals were more concerned about controlling the number of new MediCal patients, for example, by making their contracts contingent on the county hospital receiving a contract or contingent on a minimum number of other hospitals in the HFPA receiving contracts. Despite California's well-

documented low occupancy rate, hospitals showed little general interest in raising that rate with MediCal patients.

What impact did contracting have on Medicaid payments?

Contracting apparently produced sizable rate reductions. There are several different ways to measure these reductions. The most useful comparison is between rates paid under contracting and the rates which would have been paid had the previous system remained in place. (See Figure 6.) The study estimated that rates paid for services offered between the onset of contracting and September of 1983 averaged $546 per day, or 25 percent lower than they would have been under the old system. This reduction is based on interim rates, prior to the state's audit settlement at the end of each year. When an estimate of these final settlements is taken into account, the rate reduction was 16 percent. Savings may continue to grow, since the policy on contract renegotiation is to allow no net increases. As of September 1984, the state had held to that policy.

The degree of rate reduction was not equal across all hospitals or types of hospitals. By far, the greatest savings were extracted from state teaching hospitals. County hospitals, on the other hand, experienced rate reductions slightly lower than average. Hospitals which were able to negotiate multiple rates--as opposed to the single all-inclusive rate preferred by the negotiation--had the smallest rate decreases.

The net effect of these lower rates is a drastic reduction in state expenditures, even with some offsetting increases in the per diem of non-contracting hospitals (which continued to handle emergency cases). The state estimates final aggregate savings at $140 million below what would have been spent for services provided in fiscal year 1983-84 and a cash flow reduction during that year of $179 million. Koetting and Olinger's analysis basically confirmed this estimate of savings.

What was the impact on MediCal recipients?

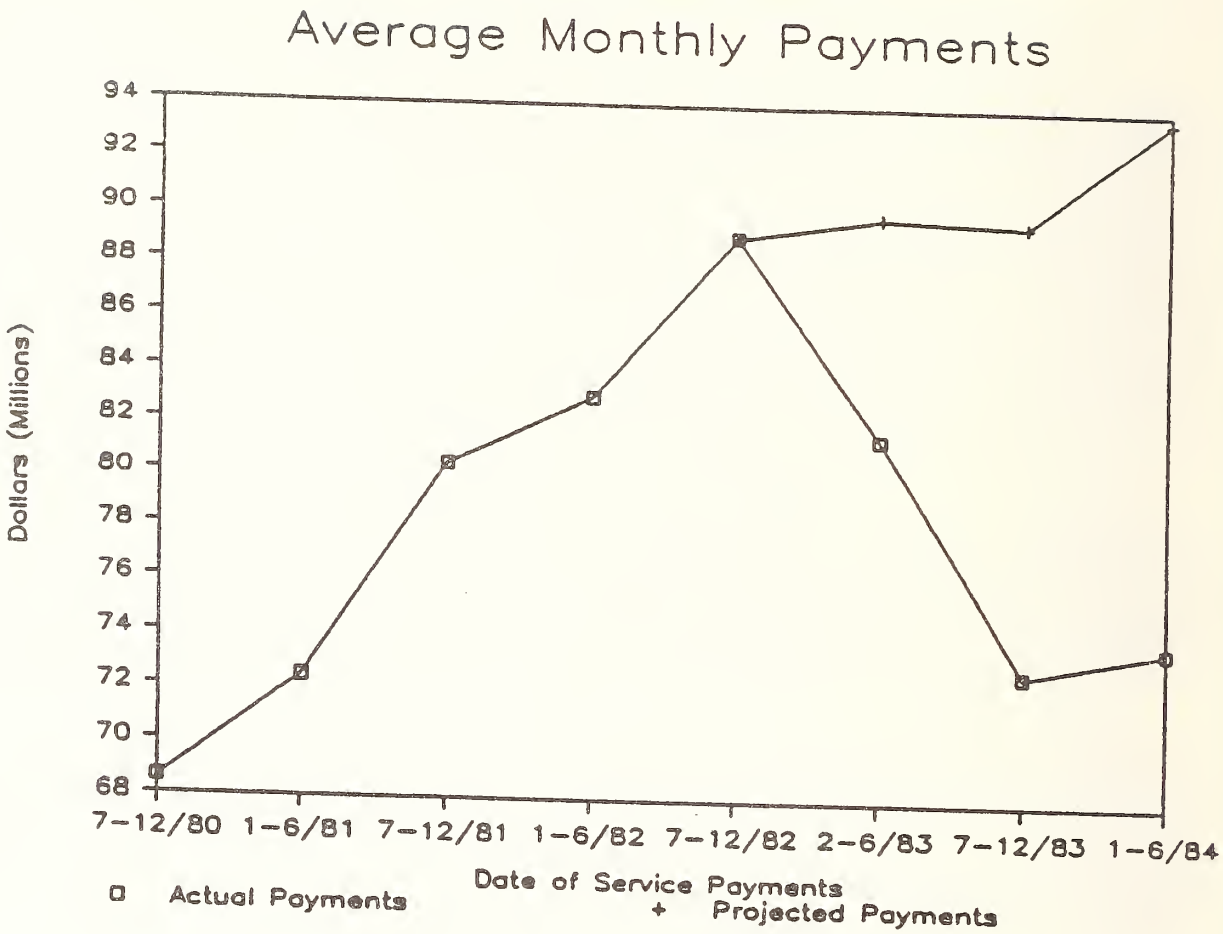
The initiation of hospital contracting generated significant concern about dislocation of patients and disruption of access. Interviews with hospitals, physicians, state officials, and consumer advocacy groups suggest, however, that these problems did not materialize. In large part, this outcome reflects the fact that most major MediCal providers received contracts. However, per diem rates that do not vary with patient condition might still have produced avoidance or transfer of expensive patients. Has "dumping" occurred?

None of the hospitals studied thought that the level of dumping had increased as a result of contracting. It was the general contention of hospitals that volume, private as well as MediCal, had decreased so much in recent months, MediCal and other, that hospitals were reluctant to transfer any patient they could legitimately keep.

In contrast, personnel in two of the five state field offices visited thought dumping was a significant problem. However, this perception was not

Figure 6

CALIFORNIA SAVINGS**



AVERAGE PER DIEM REDUCTION*

MEASURED AGAINST INTERIM PAYMENTS: (I.E., CASH FLOW)	25%
MEASURED AGAINST FINAL PAYMENTS: (I.E., AFTER YEAR-END SETTLEMENT)	16%

* BETWEEN ONSET OF CONTRACTING AND SEPTEMBER, 1983.
** NON-MIA EXPENDITURES IN CLOSED AREAS.

generally supported by the special medical teams sent out by the state to follow up on incidents. The bulk of the disposed incidents resulted in a finding of no contract violation. The pattern found by the inspection team sent by the state is more consistent with the hospital's perception of the issue: occasional violations, but not a major or systematic problem.

Part of the concern about patient dumping arises from a residual uncertainty about what services hospitals are really obligated to provide. Hospitals may transfer patients, consistent with the terms of their contract, if they have not contracted for the services these patients required. Although not a contract violation, this behavior may be perceived as dumping by outside parties.

The state has developed a rather extensive system for handling complaints from recipients. Almost all of the processed complaints were evaluated to be consistent with the provisions of the contract, and therefore acceptable. Most of the complaints resulted from uncertainty as to what services hospitals were obligated to provide. However, the state reports showed a large number of unprocessed complaints.

What impact did contracting have on other payers?

Although it is difficult to measure or attribute responsibility for cost-shifting, interviews with a small sample of private payers did not reveal particular concern about cost-shifting due to MediCal contracting. Rather, private payers were enthusiastic about hospitals' increased attention to cost reduction and efficiency, from which they as well as public payers would benefit. Interestingly, private payers' own contracting efforts were barely off the ground in 1984. Blue Cross, whose Prudent Buyer program is the most widely advertised private contracting effort, had about 300,000 enrollees in the program in September 1984--200,000 of whom had come from conversion of individual contracts. However, Blue Cross was hoping to have 800,000 enrollees by the end of 1984, because of an open-enrollment period toward the year's end.

What lessons does California contracting offer other states?

California's experience can be considered a success. A short-term assessment suggests that its contracting approach reduced costs, with a minimal amount of public outcry and without apparent harm to patients.

The main reason that contracting was successful is that it is a very powerful rate-setting approach. When MediCal, as the second largest individual payer in California, chose to exercise its considerable market leverage, rates came down.

Beyond market power, there were probably four factors which were critical to California's success:

- the legislature's willingness to grant extraordinary powers to the contracting agency;

- the state's good fortune to choose a program administrator who was willing and able to fully exploit those powers;

- the surplus of hospital beds and physicians in California which made the implied threats of contracting quite credible; and

- the existence of powerful utilization controls to accompany daily rate reductions.

Whether other states face this configuration of political and economic factors that made contracting possible and effective in California is unclear.

Furthermore, there are alternative routes to the same end. California used contracting as a means to reduce rates paid to most hospitals. Rate regulation can, theoretically, achieve the same purpose, although in practice it has faced political and legal resistance to rate reduction as substantial as California's contracting produced.

Another alternative is capitation. California envisions contracting for hospital services as only an interim step to contracting for all services on some kind of capitation basis. Other states, with less of an immediate fiscal crisis than that faced by California in 1982, may find it makes more sense to attempt to move directly into capitation programs. A capitation program is theoretically preferable since it places responsibility for both cost and utilization with the provider rather than requiring continual state intervention to control utilization. Capitation may be preferable in states that lack California's very stringent utilization review program--with prior authorization for every admission and concurrent review on a day-by-day basis by the state.

Regardless of approach, lowering rates for Medicaid recipients raises the potential issue of two-class medical care. Contracting, rate regulation, or capitation may segregate Medicaid recipients in particular hospitals. If private insurers become reluctant to locate their patients in those hospitals, questions about these institutions' financial viability and quality of care will arise. These potential problems must be recognized if policies are to maintain quality and access as well as achieving fiscal control.

V. FREEDOM OF CHOICE

The initial requirement that Medicaid programs give beneficiaries "freedom of choice" among providers reflected the program's original commitment of mainstream medical care for the poor. Alongside that commitment, however, has come a growing interest in prudent purchasing and innovative systems of delivering and reimbursing for care; arrangements that offer efficiencies but also somewhat restrict beneficiaries' choices among providers. To promote these efficiencies, Section 2175 of OBRA allowed exceptions to the longstanding freedom-of-choice requirement. Exceptions are of two general types, with and without a waiver of federal rules. First, HCFA is authorized to grant waivers for freedom-of-choice requirements to permit state Medicaid programs to:

- implement a primary care case management system or a specialty physician services arrangement;
- allow a locality to act as a central broker in assisting Medicaid recipients in selecting among competing health care plans;
- share with recipients, through the provision of additional services, savings resulting from recipients' use of more cost-effective medical care; and
- restrict recipients to receiving services (other than in emergency situations) from only efficient and cost-effective providers.

Second, without waivers, states will no longer be considered out of compliance with Federal requirements if they engage in volume purchasing (through a competitive bidding arrangement or otherwise) for laboratory and x-ray services or medical devices; restrict or "lock-in" (for a reasonable period of time) choice of providers by beneficiaries identified as overusers; and exclude from Medicaid or "lock-out" providers identified as abusing the program.

This chapter reviews states' responses to changes in freedom-of-choice requirements. For each area of flexibility, the discussion answers the following questions: How have states responded to the new authority? Why have some options been chosen and others rejected? What types of new programs have developed? What is the impact on people, providers, expenditures? The discussion summarizes material presented in Lawrence Bartlett et al., "A Descriptive Analysis of States' Responses to the Provisions of Section 2175 of P.L. 97-35, the 1981 Omnibus Budget Reconciliation Act," MPE Working Paper 4.1, January 1985.

Delivery System Changes

Among OBRA's new authorities, the opportunity to develop new systems for efficient service delivery is perhaps the most significant for the long-run development of Medicaid and health financing. Provided the states assure (and then demonstrate) that new arrangements reduce Medicaid outlays without

sacrificing beneficiary access to quality care, OBRA allows waivers of freedom-of-choice and other Medicaid requirements for four types of innovation: primary care case management systems; restricting beneficiaries to cost-effective providers; establishing localities as brokers in helping Medicaid beneficiaries choose among insurance plans; and arranging to share with beneficiaries (through provision of additional Medicaid services) savings resulting from use of more cost-effective medical care.

How have states responded to freedom-of-choice waivers?

Between October 1981 and August 1984, 25 states submitted requests for 62 programs. In general, these changes in conventional service delivery can be characterized as case management or restricted provider programs, though some of them have also used the other two new OBRA authorities.

Table 11 highlights the relationship between the different types of programs for which states have submitted waiver requests and their current status. It identifies waiver programs by type of program, status, and state. As indicated in the lower right corner of the table, 62 waiver programs have been submitted by a total of 25 states. Of all proposed waiver programs, 31--half--have been submitted by 16 states to establish primary care case management (PCCM) systems for basic medical care. As of August 31, 1984, HCFA had approved 22 of these PCCM program proposals. This represents the vast majority of approved waiver programs of all types, which number 30. A final HCFA decision had not been made on three PCCM program proposals and six others had been withdrawn by the submitting states. No PCCM proposal had been denied outright by HCFA. Of the 22 approved PCCM programs, only 13 have actually been implemented.* The nine others have either been terminated by the states or have not yet become operational.

Five waiver proposals involve primarily the delivery of mental health services. Some of these rely on the subsection 1915(b)(1) authority, some on the subsection (b)(4) authority, and some on both authorities. Three mental health waivers have been approved and implemented, and two proposals are still pending before HCFA.

With respect to selective contracting proposals, excluding those that deal only with mental health services, eight states have submitted waiver requests for a total of ten programs. Of these, three proposals have been approved and implemented, two have been withdrawn by the states, and three are still pending before HCFA. The remaining two programs have had their waivers approved but have not been implemented by the states.

Finally, 16 other proposals were submitted by 12 states. This group includes two proposals dealing with dental services and one prepaid long-term

---

*Two of these programs are the New York and Michigan HMO lock-in programs, which did not represent new financing or delivery approaches, but rather the continuation of policies that had been in place prior to 1981 but could not be continued without waivers, due to OBRA changes.

Table 11

SUMMARY OF PROGRAMS FOR WHICH WAIVERS HAVE BEEN REQUESTED UNDER SECTION 1915(b)

STATE		PROGRAM NAME/DESCRIPTION	DATE SUBMITTED	STATUS	DATE OF HCFA OR STATE DECISION	EFFECTIVE DATE FOR APPROVED PROGRAMS	WAIVER AUTHORITY: SECTION 1915(b): (1)	(2)	(3)	(4)	NSP	TYPE OF PROGRAM: CM	MH	SC	OTH	MODIFICATIONS	RENEWAL REQUEST
CA	1	On-Lok	7/06/82	W	8/18/82		(1)					CM					
CA	2	Selective Hospital Contracting	7/13/82	A/I	9/21/82	10/01/82				(4)				SC			7/84-P
CA	3a	Selective Contracting for MH Svcs.	9/22/82	W	7/28/83					(4)			MH	SC			
CA	3b	Selective Contracting for MH Svcs.	9/09/83	P						(4)			MH	SC			
CA	4	PCCM	9/30/82	A	12/20/82	1/01/84*	(1)					CM				1-A	
CA	5	Contracting w/Counties for XIX (2)	12/16/82	W	5/18/83		(1)			(4)		CM					
CA	6	Phase-In of 6-month Guar HMO Elig	12/16/82	W	10/27/83		(1)					CM					
CA	7	San Mateo Organized Health System	12/07/83	P			(1)			(4)		CM					
CA	8	Expanded Choice of H Care Plans	4/02/84	P			(1)			(4)		CM					
CO	1	PCCM--Rocky Mountain HMO	1/29/82	A/NI/T	3/03/82	3/03/82	(1)					CM					
CO	2	Primary Care Physician Program	6/25/82	A/I	8/02/82	5/01/83*	(1)					CM				2-A/D	
CT	1	Transportation Copayments	12/03/81	D	3/02/82				(3)						OTH		
CT	2	Transportation Copayments	5/03/82	D	7/29/82				(3)						OTH		
GA	1	Dental Case Mgmt for Children	1/10/83	P			(1)					CM					
HI	1	Provide Elig Info to HMO	6/30/82	W	10/12/82						NSP				OTH		
HI	2	Prepaid Dental Plan	4/25/83	W	5/09/83					(4)		CM					
IA	1	Sel Cont--Pre- and Perinatal Care	8/30/84	P			(1)			(4)				SC			
KS	1	Kansas Primary Care Network	4/04/83	A/I	6/27/83	7/01/83	(1)					CM					
KY	1	"Citicare" Primary Care Network	7/19/82	A/I/T	11/10/82	6/01/83*	(1)		(3)	(4)		CM				1-A	
KY	2	Selective Hos Contracting--Fayette	6/16/83	A/NI/T	12/30/83	1/01/84				(4)				SC			
KY	3	Selective Hos Contracting--Other	10/12/83	W	5/14/84					(4)				SC			
ME	1	Drug Copayment	11/25/81	D	1/05/82						NSP				OTH		
MA	1	Primary Care Case Management	7/21/82	A/T	10/15/82	12/28/82	(1)					CM					
MA	2	Commonwealth Health Care Corp.	7/22/82	W	12/30/82		(1)					CM					
MI	1	Physician Primary Sponsor Plan	11/10/81	A/I	2/09/82	7/01/82*	(1)		(3)			CM				2-A	9/84-P
MI	2	Capitated Ambulatory Plang	11/30/81	A/I	4/22/82	4/21/83*	(1)					CM				3-A	
MI	3	6-month HMO Lock-In	12/16/81	A/I/E	4/14/82	1/01/82				(4)		CM					
MI	4	Copayments	6/28/82	D	9/23/82				(3)						OTH		
MI	5	Primary MH Clinic Sponsor Program	10/07/82	A/I	2/17/83	2/17/83	(1)			(4)			MH				4/84-P

* Modification changed initial effective date.

Waiver Authority: NSP = No specific provision of 1915(b); e.g., 1915(b)(1).

Status Codes: A = Approved, D = Disapproved, P = Pending, W = Withdrawn, I = Implemented, NI = Not (Yet) Implemented, T = Terminated by State, E = Expired

Type of Program: CM = Primary Care Case Management, MH = Mental Health Programs, SC = Selective Contracting, OTH = Other

Table 11 (continued)

SECTION 1915(b) WAIVER SUMMARY (con't)

STATE	PROGRAM NAME/DESCRIPTION	DATE SUBMITTED	STATUS	DATE OF HCFA OR STATE DECISION	EFFECTIVE DATE FOR APPROVED PROGRAMS	WAIVER AUTHORITY: SECTION 1915(b): (1)	(2)	(3)	(4)	NSP	TYPE OF PROGRAM CM	MH	SC	OTH	MODIFICATIONS	RENEWAL REQUEST
MS 1	Extra Hos Days/Low Birth-Weight	2/05/82	W	3/16/82						NSP				OTH		
NE 1	Limits on Psychiatric Services	11/17/81	W	12/02/81						NSP				OTH		
NV 1	PCCM--U NV Medical School	6/27/83	A/I	9/27/83	9/27/83	(1)					CM					
NV 2	Single Source Pharmacy Project	12/07/83	W	3/21/84					(4)				SC			
NH 1	Impose Higher Copayments	10/20/81	D	1/25/82												
NH 2	HMO Case Management	3/31/82	A/NI/T	6/01/82	1/01/83	(1)		(3)			CM			OTH	1-A	
NY 1	5-month HMO Lock-In	2/22/82	A/I/E	5/11/82	5/11/82	(1)					CM					
NY 2	Limit Psych Svcs to Org MH Clinics	3/24/82	P						(4)			MH	SC			
NY 3	Selective Cont for Transportation	1/13/84	P						(4)				SC			
NC 1	Gatekeeper/Capitation w/Incentive	8/24/82	A/NI	3/08/83	1/15/83	(1)		(3)			CM				1-P	
OH 1	HMO Copayment Exemption	8/23/82	W	9/30/82												
OH 2a	Structured Provision of 2176 Svcs	1/11/84	W	2/27/84				(3)						OTH		
OH 2b	Selective Contracting--Home Care	4/09/84	P						(4)				SC			
OR 1	Partially Capitated PCCM	7/22/84	A	3/15/84	3/15/84	(1)			(4)				SC			
PA 1	Primary Care Case Management	3/08/82	W	6/25/82		(1)					CM					
PA 2	Primary Care Capitated Program	5/04/82	A/I/E	6/30/82	6/30/82	(1)					CM					
PA 3	PCCM thru HIOs in Metro Areas	8/18/83	W	10/28/83		(1)					CM					
TN 1	Maury County Case Mgmt Project	12/07/82	A/I	3/01/83	3/01/83	(1)					CM					
TN 2	South Memphis/Shelby Co Case Mgmt	12/07/82	A/NI	3/01/83	3/01/83	(1)					CM				1-P	
TN 3	North Memphis/Shelby Co Case Mgmt	12/07/82	A/NI/T	3/01/83	3/01/83	(1)					CM					
TN 4	TN Primary Care Network--XIX Plus	1/21/83	A/I	4/19/83	12/01/83*	(1)		(3)			CM				1-A	
UT 1	Choice of HMO or PCN	11/24/81	A/I	3/23/82	3/23/82	(1)	(2)				CM					3/84-A
UT 2	Selective Contracting for Hos Svcs	12/27/82	A/NI	3/11/83	9/09/83				(4)				SC			
UT 3	Social Services Health Plan	9/02/83	A/I	3/05/84	1/01/84				(4)			MH	SC			
UT 4	Selective Contracting--Home Health	7/13/84	P						(4)				SC			
WA 1	Modify UR/UC Requirements	10/16/81	D	1/13/82		(1)								OTH		
WA 2	Higher Copayments for ER/OPD	10/26/81	D	1/20/82		(1)								OTH		
WA 3	Capitated Drug Plan for NIIs	4/19/82	A/I	9/16/82	7/01/83*				(4)				SC		1-A	
WV 1	WV Capitated Case Management	4/12/83	W	4/21/83		(1)					CM					
WI 1a	HMO Preferred Enrollment--Phase 1	2/11/82	A/I/T	5/12/84	4/01/83*	(1)		(3)			CM				2-A/P	5/84-D
WI 1b	HMO Preferred Enrollment--Phase 2	7/27/82	P			(1)		(3)	(4)		CM				(treat as new)	
WI 2	Mental Health Gatekeeper Plan	2/11/82	A/I	11/08/82	11/08/82	(1)			(4)		CM	MH	SC		1-W	
WI 3	Non-HMO PCCM	8/27/82	A/NI	1/05/83	1/05/83	(1)					CM					
WI 4	Waive Medically Needy Elig Req	11/01/82	D	2/10/83						NSP				OTH		
WI 5	Provide Home Care for MR Popn	2/22/83	W	7/13/83						NSP				OTH		

care program, as well as 13 other proposals that could not be clearly linked with any of the specific waiver authorities in section 1915(b). Of this group, eight were disapproved by HCFA, seven were withdrawn by the state, and one (a dental case management plan) is technically still pending but is not being pursued by the state.

Of the approved waiver programs, all but three (Utah's case management plan and the HMO-related arrangements in Michigan and New York) became effective in late 1982 or after--too late to have an impact on Medicaid spending in 1982. The following discussion concentrates on case management systems, which represent half of all freedom-of-choice waiver requests and three-fourths of all approved programs. (See Figure 7 which shows states with implemented waiver programs.)

What is a case management system?

The basic notion of a case management system is quite simple. The Medicaid recipient selects (or is assigned) a primary care physician or other primary care provider (e.g., a community health center), who becomes that recipient's case manager. Thereafter, except in a true emergency, all care must be provided or arranged and authorized in advance by the case manager.

Who have states included in their case management systems?

The two aspects of the target population question are: In what geographic areas of the state will the PCCM system operate, and what categories of recipients will it serve? Table 12 shows the choices states have made on these and other issues.

All but two of the approved PCCM systems have received waivers to operate on less than a statewide basis. (The two exceptions are Michigan's and New York's now expired waivers to allow lock-in of HMO enrollees for a six-month period. Although their waivers did not include statewideness, as a practical matter the programs only had an impact in areas of the two states that had HMOs.)

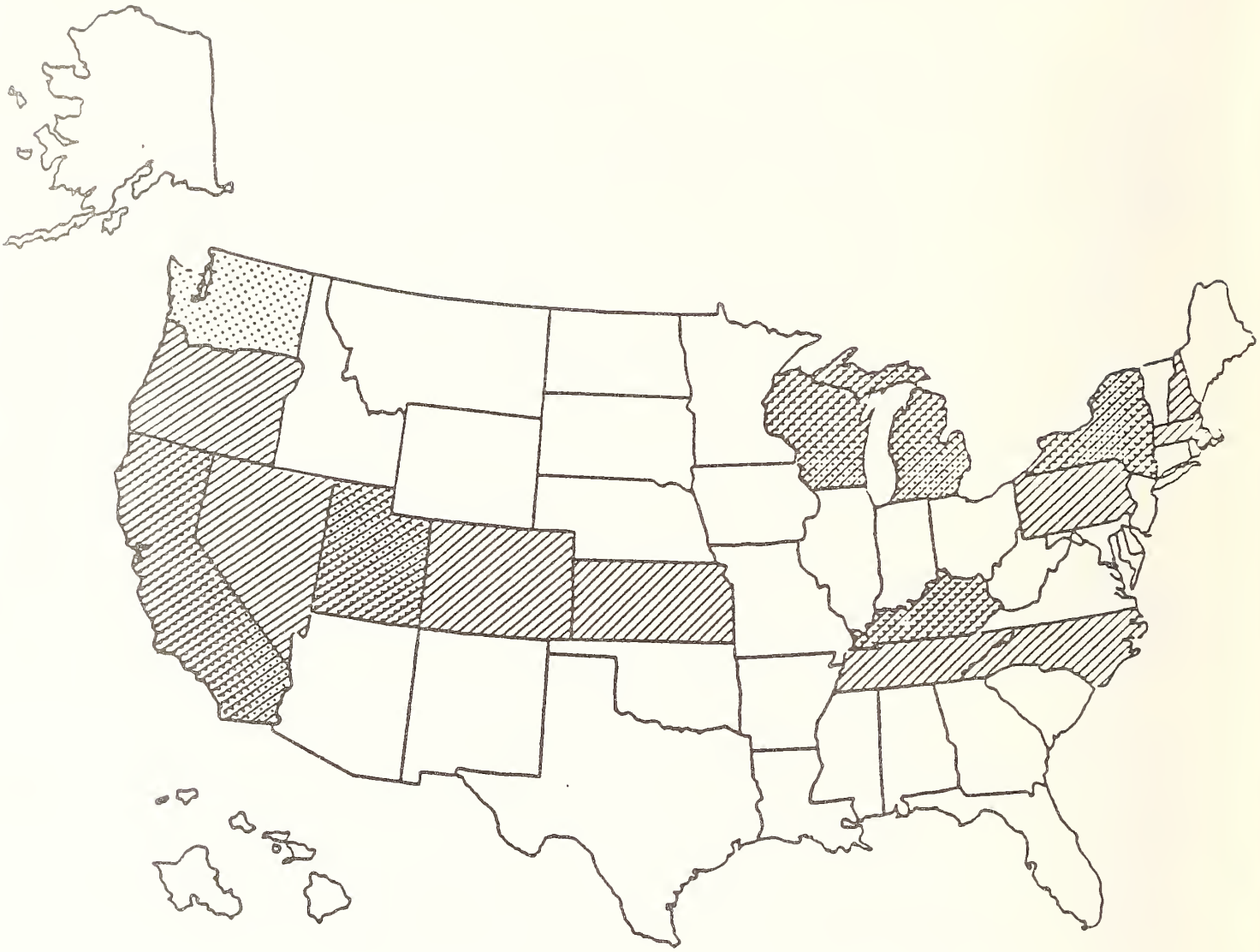
Most of the operating PCCMs are expected to expand and several are slated already to become statewide over time. These include the programs in Colorado, Utah, Kansas and Tennessee. All the PCCMs started to operate in specific substate areas. In several instances, the initial efforts were specifically targeted on the major population centers, with their high concentrations of Medicaid recipients. Michigan operates its Physician Primary Sponsor Plan in the Detroit area; Kentucky's arrangement with "Citicare" covered only the Louisville area; and Nevada's University of Nevada Medical School program is available only in Reno and Las Vegas. A few of the programs, such as Tennessee's Maury County Case Management program and North Carolina's yet-to-be-implemented gatekeeper plan in Wilson County, have been designed to operate in less densely populated rural areas.

Generally, states have chosen to limit PCCM enrollment to certain groups of Medicaid recipients. The Medicaid-eligible AFDC population is most often the primary eligible population. All of the approved PCCMs are open to AFDC

Figure 7

APPROVED WAIVERS

August 31, 1984



▨ = PCCM ⁘ = OTHER ▨ = BOTH

22 OF 30 APPROVED WAIVERS ARE FOR PRIMARY CARE CASE MANAGEMENT (PCCM).

539,000 RECIPIENTS OR 3 PERCENT OF THE 1983 MEDICAID POPULATION ARE EXPECTED TO PARTICIPATE IN PCCMS.

Table 12

STATE PCCM CHARACTERISTICS
(IMPLEMENTED PROGRAMS)

State/Program	Characteristic					
	Area	Case Manager	Covered Population	Reimbursement	Recipient Enrollment	Other
1. Colorado/ Primary Care Physician Program	Statewide, except underserved and rural areas	Mostly private primary care physicians, some HMO	All AFDC; 90,000	FFS, no case management (CM) fee	Mandatory	Possible shared savings with physicians
2. Kansas/ Primary Care Network	3 rural and small urban counties	Physicians	All recipients except children in: -foster care -subsidized adoption, and dual eligibles; 24,500	FFS and $3 case management fee per month per enrollee	Mandatory	Total CM fee limited to $6,000 per year per case manager
3. Kentucky/ Citicare (terminated by state 6/84)	Jefferson County (including Louisville)	Primary care physicians	All AFDC except medically needy; 48,000	HIO=95% of FFS PCP=partial rate of capitation rate	Mandatory	HIO=Citicare accepted only 1% of the risk initially PCP=various financial incentives established for PCPs
4. Michigan/ Primary Physician Sponsor Program	Wayne County (Detroit)	Primary care physicians	All except: -institutionalized -crippled children -dual eligibles Optional for MN; 370,000	FFS and $3 case management fee per month per enrollee	Voluntary	Total CM fee limited to $3,000 per mo. per sponsor. (But sponsor may enroll up to 2,000)
5. Michigan/ Capitated Ambulatory Program	4 counties: -Kalamazoo -Wayne -2 others	Five clinics	All except: -institutionalized -crippled children	100% of FFS (ambulatory services only)	Voluntary	If hospital costs are less than 80% of expected FFS amount for a CAP provider's enrollees, savings beyond that amount are split 50/50 between the CAP provider and the state, subject to a maximum
6. Michigan/ 6-month HMO Lock-in	Wayne and Saginaw counties	HMO	Excluded are: -institutionalized -medically needy -long-term home health recipients	Capitation at full rate, 90% of FFS or less	Voluntary	----
7. New York/ 6-month HMO Lock-in	NYC and some upstate areas	HMO	Excluded are: -institutionalized -medically needy -long-term home health recipients	Capitation at full rate, less than 95% of FFS	Voluntary	Exact rates not known
8. Nevada/ University of Nevada Medical School	Las Vegas and Reno	Physicians	AFDC	Partial rate of capitation at 100% of 1982 FFS	Voluntary	Implemented in 1983 with no inflation adjustment. Includes drugs
9. Pennsylvania/ Primary Care Capitated Program	Wilkes-Barre Area	Physicians	All except: -medically needy -dual eligibles; 4,000	Full rate of capitation at less than 95% of FFS	Voluntary	----

recipients, while fully half are available only to them. Nine PCCMs also provide coverage to aged, blind, or disabled individuals who meet the SSI-related eligibility requirements for Medicaid coverage. However, individuals who are eligible for both Medicaid and Medicare, a large portion of the non-AFDC population, are often excluded from participating in PCCM programs. Individuals residing in long-term care institutions are another frequently excluded group. Finally, most programs exclude the medically needy.

How do case management systems operate?

Case management systems may be voluntary or mandatory--in other words, Medicaid beneficiaries may have the choice of enrolling in a system or may be required to enroll. (In either arrangement, the beneficiary may be restricted to services provided or arranged by the case manager.) Enrollment levels across the PCCM sites are compared in Figure 8. Of the 11 implemented case management programs, seven were mandatory--enrolling about 209,000 Medicaid beneficiaries. The four voluntary programs enrolled only about 7,000 beneficiaries.

The mandatory programs appear to have been established in areas with larger Medicaid populations, and the percentage of eligible recipients electing to enroll in voluntary programs has been rather small. As was indicated in Table 12, most of the mandatory programs have made substantial penetration into their target populations. Only Michigan's Primary Physician Sponsor Program has enrolled less than half of the program's target population. On the other hand, voluntary programs have enrolled only about 10 percent or less of the potentially eligible recipients in the areas in which these programs operate.

Are case management plans at financial risk?

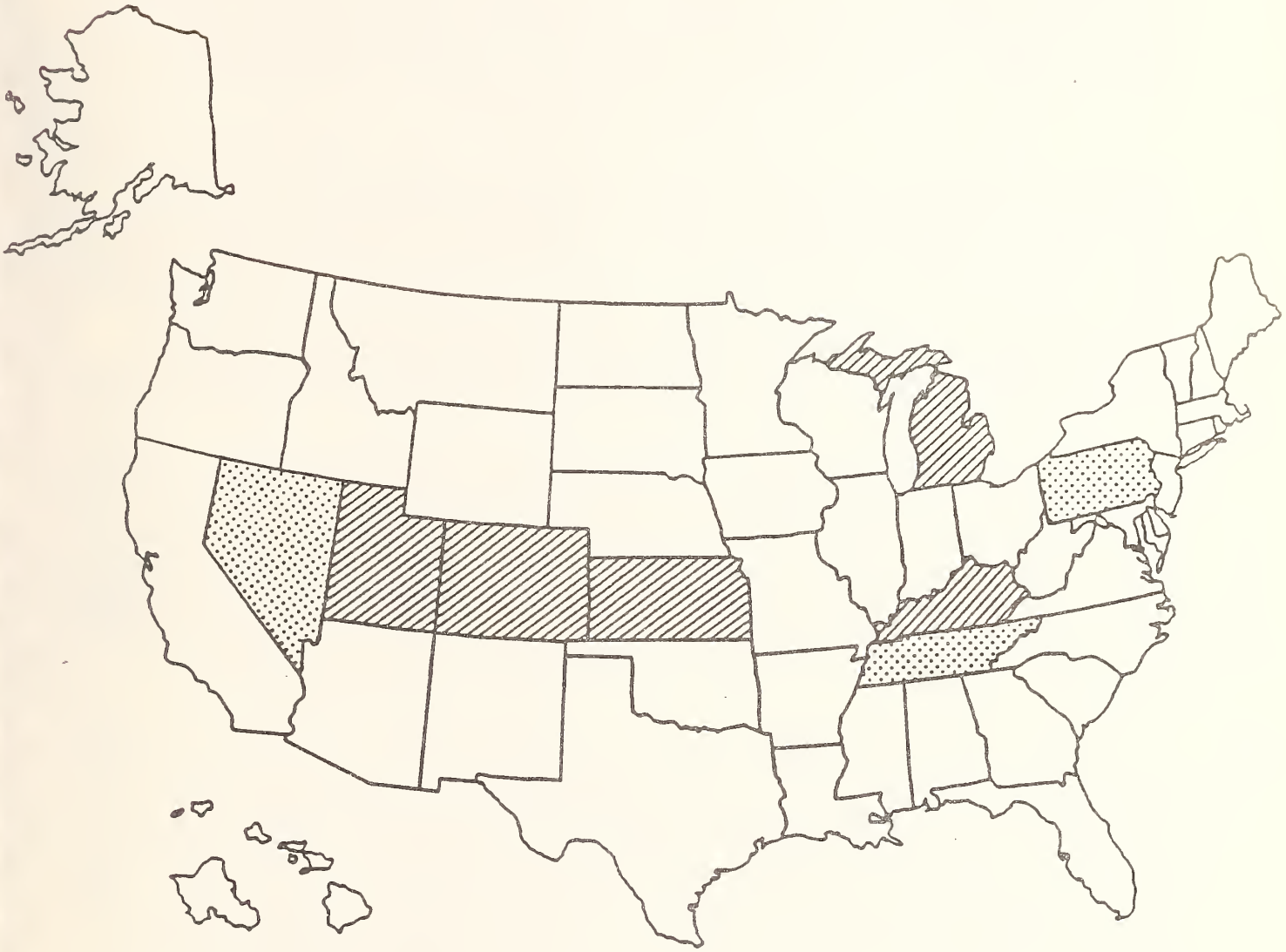
In concept, the PCCM approach should reduce costs by providing needed care more efficiently and reducing the amount of unneeded or unnecessarily expensive care. But, when the state operates the system directly, the state remains at risk and may suffer losses if the concept does not work out in practice. If the state can find an outside organization willing to operate the system and bear the financial risk, the state can budget its expenditures more accurately and assure itself of savings.

These dual concerns obviously suggest an advantage to states in contracting with HMOs and other prepaid health plans (PHPs) that have experience in controlling utilization, usually through a case management approach, and in bearing financial risk. And, over the years, many states have done so. As of June 1984, 23 states had contracts with 70 HMOs/PHPs to enroll Medicaid recipients. In four of the approved PCCM waiver programs, the state deals solely with HMOs or PHPs.

However, there are several factors that limit states' ability to enroll significant numbers of Medicaid recipients in HMOs/PHPs. Chief among these are the unavailability of many mainstream HMOs to Medicaid patients, combined with the statutory requirements that enrollment in HMOs/PHPs be strictly voluntary and that HMOs serving Medicaid patients also have significant

Figure 8

RECIPIENT PARTICIPATION IN PRIVATE PHYSICIAN PCCMS



▨ = 10,000 OR OVER ▩ = UNDER 10,000

MOST RECIPIENTS CONCENTRATED IN A FEW STATES, NOTABLY MICHIGAN, KANSAS, UTAH, AND COLORADO.

ABOUT 220,000 ENROLLEES IN PRIVATE PHYSICIAN-BASED PCCMS BY MID-1984.

private enrollment. Further, states' Medicaid benefit packages are usually quite rich, and Medicaid recipients are not required to pay any premium for their coverage. Thus, it is very difficult to fashion an HMO/PHP option for Medicaid recipients that will induce a significant number of recipients to enroll voluntarily. And, in fact, only slightly over 440,000 Medicaid eligibles were enrolled in HMOs or PHPs as of June 1984, representing less than 3 percent of total monthly Medicaid enrollees.

An alternative that has emerged is the use of the "health insuring organization" (HIO) under Federal Medicaid regulations, combined with a section 1915(b)(1) waiver to permit the HIO to operate a PCCM system. The HIO option has existed in Federal regulations for a long time. It permits states to cover their Medicaid population by, in effect, buying private insurance for them. The Texas Medicaid program has operated in this way since its inception, and the Redwoods Health Foundation has covered Medicaid eligibles in three California counties since 1973. These insurers operate standard Medicaid programs without waivers, although they perhaps pay particular attention to good utilization control procedures.

Despite these early examples, interest in HIO approaches did not begin to spread until PCCM waivers became available and TEFRA restricted section 1903(m) waivers. PCCM systems make accepting risk more feasible for private organizations, because of the real opportunities for cost and utilization control they offer. HIOs are attractive to states because they can be paid on a capitated, at-risk basis without regard to the section 1903(m) requirements that govern and constrain prepaid contracts with providers* and because they will develop and operate the management information systems necessary to support PCCM systems.

Unlike HMOs, however, HIOs may not be "closed panel," i.e., they may not arbitrarily choose to deal only with certain providers in a given area. Because they are considered fiscal agents of the state, they must deal with all Medicaid-participating providers who wish to continue to serve Medicaid patients under the HIO arrangement. There is one exception to this rule. The state may, on behalf of the HIO, obtain an OBRA-authorized "restrict providers" waiver under section 1915(b)(4). If this is done, the HIO, as the agent of the state, may establish objective criteria that it will then use to determine whether or not to subcontract with a particular provider.

The combined HIO/PCCM approach was initially used for the Kentucky "Citicare" program. "Citicare" operated as an HIO and served all AFDC recipients in Jefferson County (Louisville) from July 1983 until it was terminated by the state for unspecified reasons in June 1984. The Tennessee "Medicaid Plus" program is an HIO which is offered as an option to Medicaid recipients in several counties.

---

*HIOs are exempt from these requirements because they are not providers of care and do not accept medical responsibility for any patient.

How do case management systems pay their primary care case managers?

Approaches to paying primary care physicians under different arrangements are shown in Table 12. Of the eleven operating case management plans, two (Wisconsin and Pennsylvania) involve capitation payments to HMOs. Five plans pay on a fee-for-service basis. Three of these fee-for-service plans (Kansas' Primary Care Network, Michigan's Physician Primary Sponsor Plan, and Tennessee's Maury County Case Management Program) include a $3 per month fee for case management. Two (Colorado and Utah) do not.

Two operational case management programs (Nevada's University of Nevada Medical School Program and Michigan's Capitated Ambulatory Plan) involve "partial capitation" arrangements, paid directly by the state to primary care case managers.

Finally, the two HIO-operated PCCM systems approved to date (Kentucky's "Citicare" and Tennessee's "Medicaid Plus") have involved partial capitation arrangements with the primary care providers. Federal Medicaid rules (section 1903[m]), however, limit the extent to which actual providers of care can be placed at risk (unless they are HMOs or PHPs). Individual physicians, for example, cannot be placed at risk for inpatient hospital costs; nor can they be placed at risk for more than two of the services mandated in the Federal Medicaid statute. Both states and, as administrative extensions of the state, HIOs are bound by these limitations. Therefore, primary care providers/case managers are usually capitated only for a limited package of primary care services, typically the PCP's own services and one other.

Despite the limits on capitation, provisions in the Federal statute do permit some risk/incentive arrangements with PCPs. In particular, services of referral specialists are "physicians' services," as are the PCP's own services. Inclusion of such services under the capitation payment to the PCP would therefore not violate the "two services" rule, even if laboratory and x-ray services were also included, as they often are. More commonly, specialists' services would not be included in the direct capitation payment to the PCP but would be paid by the HIO from a separate pool, with the PCP sharing in the risk if expenditures exceeded the budgeted allocation. Federal rules also permit special arrangements to share with PCPs any savings that result from lower-than-expected hospital utilization, so long as the PCP is not at risk for higher utilization.

When the PCP is partially capitated, payments to specialists themselves usually remain on a fee-for-service basis, as do payments to hospitals for inpatient care. For example, in the "Citicare" program the capitation payment to PCPs included the PCP's own services and a limited number of common laboratory tests. PCPs were also put at limited risk for consultant, emergency room, and home health services that they authorized; and they were to share in the savings if these services and hospital utilization stayed within budgeted amounts. For "Medicaid Plus," the basic capitation payment to PCPs includes the PCP's own services and laboratory and x-ray services. Other (optional) Medicaid services, primarily prescription drugs, may be included in the capitation payment under some PCP contracts.

How have the case management systems affected people, providers, and expenditures?

These questions have not yet been analyzed and are the focus of further research efforts. One plan, the Michigan Physician Primary Sponsor Plan, has been targeted for a three-year case study.

Officially started in July 1982, PPSP is a delivery plan in which recipients enroll with a single physician who thereafter provides or authorizes all non-emergency care. A $3-per-month case management fee is paid to physicians with sponsor contracts for each enrollee. Physicians whose patients exceed the 95th percentile for use of certain services risk either losing their sponsor contracts, case management fees, or having the recipient(s) with excessive use assigned to another sponsor or the state's Recipient Monitoring Project.

This initiative was selected for evaluation because it is the most ambitious Medicaid physician primary care case management projects now being conducted under waiver authority included in Omnibus Budget Reconciliation Act of 1981, section 2175. As such, there is a good opportunity to generate useful findings for future policy decision-making regarding the "freedom of choice of provider" provisions under Title XIX.

Experience with Michigan's PPSP suggests that case management systems may be more difficult to implement than policymakers anticipated. About 62 percent of physicians serving Wayne County Medicaid patients before PPSP who were expected to be case managers have not signed sponsor contracts. Similarly, about 80 percent of the recipients originally targeted for PPSP remain in fee-for-service. However, 53,940 recipients and 1,270 physicians are participating as of September 1984, a substantial achievement by comparison with other states.

How have physicians responded to Michigan's case management arrangement?

As of September 1984, there were 1,270 physicians with sponsor contracts in the Michigan program. This means that an estimated 37 percent of the primary-care-oriented physicians who served Medicaid before PPSP signed sponsor contracts. There are indications that a considerably higher than average percentage of family practice physicians, pediatricians, and general practitioners joined PPSP. Only a small proportion (4.9 percent) of the specialists that served Medicaid before PPSP now have sponsor contracts. Few (if any) would-be sponsors not previously serving Medicaid have signed contracts. Hence, while limiting the number of specialists with sponsor contracts, PPSP has been unable to retain all primary-care-oriented physicians who served Medicaid before PPSP or attract similar physicians who previously have not served Medicaid.

The availability of sponsor physicians varied considerably across Wayne County locations--offering a potential range of 40 to 1,279 recipients per sponsor. The average across all locations is 242 recipients per sponsor. The majority of sponsors are in solo or small group practices, with minimal formal affiliations with other care providers. With respect to size of sponsor's

PPSP caseloads, the best available information indicates that most sponsor physicians have PPSP caseloads of between one and 20 enrollees. Recent PPSP statistics (September 1984) reveal that only 12 sponsors had caseloads between 501 and 900 enrollees. During 1984, the percentage of sponsors without PPSP enrollees declined and the typical size of sponsor PPSP caseloads increased. By June 1984, the average number of PPSP enrollees per sponsor had risen to 44 compared to 28.8 in April 1984. Apparently, the increase is a result of new recipient enrollment methods which allow physicians to market PPSP to their patients.

To date, the best available evidence on physician perceptions of PPSP is a mail survey of 441 Wayne County physicians, conducted one month after the start of PPSP. According to this survey, physicians were generally familiar with PPSP, but varied considerably in their expressed attitudes toward its provisions. Several key findings were:

- Ninety-eight percent of physicians were familiar with PPSP.
- About 70 percent reported that patient assignment (lock-in) and case management fees would be important to their decision to join the program; 60 percent viewed prior authorization of referrals as a factor.
- Physicians tended to approve of such provisions as patient assignment (lock-in) and case management fees; they tended to disapprove of 24-hour access, the appeals procedure, use of the 95th percentile, the number of Medicaid patients per sponsor, and HMO specifications.
- Physicians expected PPSP to decrease: (1) utilization of services by Medicaid patients, (2) in-patient hospital utilization, (3) emergency room use, (4) doctor shopping, (5) drug utilization, (6) patient abuse of Medicaid, and (7) total cost of Medicaid.

Finally, this survey revealed generally negative attitudes on the part of physicians toward both Medicaid patients and the Medicaid program. This probably helps to explain the unwillingness of some physicians to become sponsors--regardless of the intensity of marketing efforts and the basic provisions and incentives included in PPSP.

How have recipients responded to the case management arrangements?

By September 1984, 53,940 recipients were enrolled in Michigan's PPSP, about 19 percent of the original target of 286,400. In addition, an estimated 15,000 additional recipients were enrolled in HMOs partly as a result of PPSP-related marketing. An examination of available enrollment data for the period July 1982 - September 1984 showed that:

- An estimated 227,000 individuals remain in fee-for-service; this is 62 percent of the PPSP-eligible Medicaid population in Wayne County.

- PPSP enrollments outpaced HMO and CAP enrollments by two to one.

- Owing to a Temporary Restraining Order, the pace of PPSP enrollments during the first 7-9 months was very slow.

- At the higher rates of enrollment achieved during the 14 months ending in September 1984, the original PPSP enrollment objective could be accomplished by December 1986.

Despite achieving a large number of enrollments, there is ample indication that the implementation has been problematic. In 26 months, there have been eight separate major initiatives designed to increase the pace of enrollments and resolve difficulties in enrolling recipients who wanted non-sponsor physicians or who failed to respond to official notices. In the first 20 months--Phase One--it was assumed that the state could fully enforce choice of a plan by recipients selected for marketing. For those who failed to make a selection, this would be accomplished by unilateral assignment of the recipient to a case manager. Eventually, owing to the problems it created, this approach was suspended in favor of a more voluntary policy--Phase Two--in which recipients are marketed in several ways and informed that failure to select a sponsor may mean assignment by the state at a later date. Regardless of the distinctions, a comparison of enrollments under each phase indicates that the approaches are about equally effective in terms of average number of enrollments per month.

Lock-in Program

How have states responded to authority to lock-in high users?

Thirty-seven state Medicaid programs currently operate recipient lock-in programs. Nine of these programs were established after OBRA's enactment. The remaining 28 programs were developed before its enactment (half of these prior to 1979), relying on their authority to set utilization controls. Several states have indicated that they have not established lock-in programs because restrictions on the number of physician visits, prescriptions or other services covered by their programs effectively preclude recipients from consuming an excessive quantity of these services.

In 1982, the year following passage of P.L. 97-35, approximately 27,500 individuals were enrolled in the 37 state Medicaid lock-in programs. The State of Illinois' lock-in program was by far the largest, with about 19,200 enrolled individuals, or roughly 70 percent of all restricted recipients nationwide. The portion of the total national Medicaid population which was actually restricted was quite small. The lock-in population represented approximately 13 of every 10,000 Medicaid recipients across the country, or roughly 19 of every 10,000 Medicaid recipients in those states with lock-in programs.

While the number of lock-in programs remained constant since 1982, the size of the restricted population has more than doubled, increasing to over

64,000 by mid-1984. Of this growth increase of nearly 37,000 individuals, over 90 percent is the result of major expansions in three states' lock-in programs--Illinois, New Jersey, and New York. The Illinois lock-in program has remained the largest, doubling in size to 42,000 individuals. Information on the size of individual states' lock-in programs is presented in Table 13.

Most lock-in programs are quite small, with the majority of states having less than 100 individuals enrolled in each of their programs. Only four programs (Illinois, New Jersey, New York, and Pennsylvania) have more than 1,000 restricted individuals.

Lock-in programs typically operate by identifying high users, manually reviewing their claims for evidence of inappropriate use, and informing the recipient that he or she is to be locked-in. The duration of a lock-in requirement varies across states. Restrictions are most often imposed for an initial period of 7 to 12 months, although this period can range from under 6 months to over 24 months. Recipients may remain locked in until monitoring shows that they have demonstrated adequate improvement in their utilization and that their usage patterns are within acceptable levels.

After the decision has been made to lock in a recipient, a primary provider is designated. Depending upon the nature of the restriction, this provider may be a physician, pharmacy, and/or other type of provider. Twenty-five of the 37 states with lock-in programs can restrict recipients to primary physicians and 23 to pharmacies. Most states (29) have the option of imposing a dual restriction, i.e., limiting a recipient to one physician and one pharmacy. Thirteen states list "other" types of providers and, of these, eight indicated that their regulations gave them maximum flexibility, allowing them to restrict recipients to any type of provider participating in their Medicaid programs.

Generally, states will pay only for ambulatory care claims submitted by the primary provider, except in cases where the primary physician has referred a recipient to another physician or in cases of documented emergencies. In the event the recipient needs specialty care or services which the primary physician cannot provide, it is the physician's responsibility to refer the recipient to an appropriate specialist. In general, states restricting recipients to one pharmacy require that the primary pharmacy be responsible for (1) dispensing prescribed drugs and medical supplies to the recipient, and (2) monitoring the drug utilization of the restricted recipient. Some states require that the lock-in pharmacy maintain a patient profile for the recipient. As a rule, only the lock-in pharmacy may bill Medicaid for pharmaceutical services provided to the assigned recipient. Prescriptions obtained in emergency situations may be an exception to this rule and in these instances payments are usually authorized.

How do lock-in programs affect people, providers, and expenditures?

At this point, evaluations of lock-in programs are limited to studies conducted by the states. These evaluations are limited in several ways. First, all states that estimated savings simply compared spending on the locked-in population before the lock-in to spending after the lock-in. Hence,

Table 13

MEDICAID RECIPIENT LOCK-IN PROGRAMS

State	Implementation Date of Program		1981 Medicaid Population	Early 1982 Lock-In Enrollment	1981-82 Restricted Individuals Per 10,000 Medicaid Enrollees	Estimated 1983 Medicaid Population	Early 1984 Lock-In Enrollment	1983-84 Restricted Individuals Per 10,000 Medicaid Enrollees
Alabama		1974	330,580	72	2.2	311,348	73	2.4
Arkansas	November	1980	219,009	8	.4	190,279	47	2.5
Colorado	January	1981	145,514	34	2.3	147,644	120	8.1
Connecticut	Rx January	1981	222,237	38	1.7	215,512	35	1.6
	All August	1982						
Delaware	January	1980	50,447	3	.6	45,618	47	10.3
D.C.	October	1982	121,054	0	--	117,715	15	1.3
Hawaii		1976	104,546	35	3.3	100,293	45	4.5
Idaho	November	1982	42,798	2	.5	39,215	5	1.3
Illinois		1976	1,110,676	19,200	172.9	1,050,992	42,000	399.6
Indiana		1976	222,336	137	6.2	271,677	166	6.1
Iowa	December	1981	195,591	8	.4	189,462	15	.8
Kansas	July	1978	148,764	195	13.1	147,201	260	17.7
Kentucky	January	1972	412,783	611	14.8	388,041	650	16.8
Louisiana	April	1979	410,448	26	.6	377,957	15	.4
Maine		1980	146,334	32	2.2	122,154	75	6.1
Maryland	October	1982	328,153	0	--	328,012	24	.7
Massachusetts	Initial: Jan	1979	746,813	109	1.5	579,079	222	3.8
	Reactivated: May	1981						
Michigan		1980	962,038	880	9.1	1,187,612	960	8.1
Minnesota	August	1976	324,008	150	4.6	326,355	145	4.4
Missouri		1972	361,117	337	9.3	290,483	308	10.6
Nebraska		1970	76,441	394	51.5	83,963	500	59.5
New Jersey	January	1981	661,132	152	2.3	611,923	8,021	131.1
New Mexico		1975	94,524	210	22.2	84,420	500	59.2
New York	September	1978	2,241,142	1,613	7.2	2,160,591	5,000	23.1
North Carolina	July	1982	382,386	0	0	349,053	0	---
North Dakota	May	1981	32,429	12	3.7	31,925	25	7.8
Ohio	March	1984	---	--	0	910,570	260	2.9
Oregon	October	1980	170,649	33	1.9	153,810	150	9.8
Pennsylvania		1976	1,089,999	2,452	22.5	1,167,222	2,782	23.8
South Carolina	September	1981	271,872	0	--	236,220	4	.2
Tennessee	December	1971	364,191	102	2.8	341,243	280	8.2
Texas	August	1982	705,843	19	.3	680,129	720	10.6
Utah	July	1981	68,090	222	32.6	66,038	245	37.1
Vermont	April	1979	56,777	5	.9	53,624	17	3.2
Virginia	July	1978	330,949	187	5.7	306,395	300	9.8
Washington	June	1980	331,375	70	2.1	257,648	230	8.9
West Virginia	October	1981	207,442	7	.3	177,351	--	---
Wisconsin	October	1981	445,203	140	3.1	480,096	150	3.1
TOTALS			14,136,350	27,495		14,598,870	61,122	

they were unable to control for a variety of factors independent of the lock-in that could have produced spending changes. Second, estimates were often on a sample of beneficiaries, which may not be representative. Third, most states made estimates of cost savings by looking only at the services for which beneficiaries were locked-in (drugs for pharmacy lock-ins; ambulatory care for physician lock-ins). The substitution of services not affected by the lock-in for services the lock-in controlled was generally not taken into account. Fourth, most state estimates did not follow locked-in recipients over time, to examine what happened to use patterns after restrictions were lifted. Fifth, states often report gross program savings that do not take administrative costs into account.

Keeping these caveats in mind, the findings on savings from lock-ins are as follows. An estimated $28.3 million in gross savings was reported by those 25 states which provided dollar estimates of the impact of their lock-in programs. All states reported savings. The range of the savings was quite wide, from $308 in Arkansas to over $16.3 million in Illinois. Similarly, the percentage of pre-restriction total expenditures for the restricted population which these gross savings represent varies from state to state. In New York, for example, gross savings were estimated at 26 percent of original expenditure levels. The Minnesota study cited above found expenditures for the entire restricted population to be reduced by 46 percent while the restriction was in place.

Because this substantial variation in total savings is due in large part to the difference in the sizes of the state programs (Arkansas has seven recipients locked in, and Illinois reports approximately 19,200 restricted individuals), a better measure of the effectiveness of these programs is perhaps the annual gross savings estimated for each lock-in recipient. Even when the sizes of the states' lock-in programs are considered, the difference in levels of gross savings is nonetheless significant, ranging from a low of $44 in Arkansas to a high of $7,500 for the Utah program. (More than half of Utah's savings comes from inpatient hospital savings.)

For the 25 states providing data on gross savings, the average annual savings per restricted recipient was $1,019.* If this estimate of per capita gross savings were applied to the approximately 986 restricted recipients in the nine lock-in states which were not able to provide savings estimates, an additional $1 million in gross savings could be attributed to lock-in programs, bringing the nationwide estimate of annual savings to $29.3 million.

Once administrative costs are calculated, they can be subtracted from gross savings to provide an estimate of the net savings of a lock-in program. Net savings for those 20 states which were able to estimate administrative costs totalled $22.1 million. Only Arkansas, which had only seven recipients in its program at the time of the survey, reported a net loss for its lock-in program. All other states experienced net savings, with annual

---

*Because the Utah program is small (150 recipients), its savings estimate does not distort the overall average.

savings from the large Illinois program estimated at nearly $18.5 million. Net savings figures are presented in column 6 of Table 14.

Column 7 of Table 14 provides estimates of annual per capita net savings. Excluding Arkansas, savings estimates ranged from $182 in Virginia to $7,333 in Utah. Across all of the listed state programs, net savings averaged $877 per restricted recipient. If this average figure were applied to the approximately 3,541 lock-in recipients in those states for which a net savings figure was not available, an additional $3,105,457 in net savings would be projected. This would bring the estimate of nationwide net Medicaid savings produced by lock-in programs to $25.2 million.

Another way of assessing the efficiency of lock-in programs is to examine the relationship between gross savings and administrative costs. The final column in Table 14 presents the values for this benefit-cost ratio for those states which were able to determine their administrative costs. With the exception of the smallest operational lock-in program (Arkansas), the data indicate that the states more than recouped their administrative costs in the form of program savings. The range is from $1.05 in savings for every dollar spent in New Jersey (which operated an essentially manual system at the time of our study) to $45 in savings per dollar expended in Utah. The average benefit-to-cost ratio for all states, weighted by program size, was $12.79 to $1. This average figure was heavily influenced by the large program in Illinois, which had an estimated return of $21.30 on the dollar. The average for all other states, excluding Illinois, was $6.85 in savings per dollar spent.

Volume Purchasing

How have states responded to OBRA's new allowance of volume purchasing?

The Omnibus Budget Reconciliation Act made one major change in Federal policy regarding the volume purchasing of goods and services by state Medicaid programs. This was the allowance of volume purchase of laboratory and x-ray services. Aside from the addition of one laboratory volume purchasing program in Nevada,* there has not been a significant change in the pattern of services selected for volume purchasing programs. The following table shows the number of known volume purchasing programs adopted pre-OBRA and post-OBRA by service, using August 13, 1981, the date of enactment and effective date, as the dividing point:

---

*In addition to the Nevada program, Kentucky Medicaid conducted (from July 1, 1983 until June 30, 1984) a comprehensive, prepaid, capitated case management program called "Citicare" for approximately 40,000 AFDC recipients in the Louisville and Jefferson County area. Citicare initiated a preferred provider contract for lab services on December 1, 1983, which ran until the Citicare project ended.

Table 14

ESTIMATED SAVINGS ATTRIBUTED TO STATE MEDICAID LOCK-IN PROGRAMS (1982), BASED ON COMPARISON OF EXPENDITURES MADE BEFORE AND DURING THE RESTRICTION PERIOD
(Range of services included in estimates may vary from state to state)

State	Number of Restricted Recipients	Annual Program Savings (Gross)	Annual Gross Savings Per Restricted Recipient	Annual Administrative Costs ($)	Annual Program Savings (Net)	Annual Net Savings Per Restricted Recipient	Ratio of Gross Savings to Administrative Costs
Arkansas	7	$ 308	$ 44	$ 35,000	$ (34,692)	$(4,956)	.008
Connecticut*	38	25,600	674	6,600	19,000	300	3.88
Delaware	11	9,214	838	N.A.	N.A.	N.A.	-
Hawaii	35	61,250	1,750	Neg.	61,250	1,750	-
Illinois	19,200	16,344,000	851	767,000	15,577,000	811	21.3
Indiana	154	170,900	1,110	30,000	140,900	915	5.7
Iowa	10	18,820	1,882	N.A.	N.A.	N.A.	-
Kansas	225	337,500	1,500	176,590	160,910	715	1.9
Kentucky	258	196,080	760	30,000	166,080	644	6.54
Maine	41	32,144	784	N.A.	N.A.	N.A.	-
Maryland*	500	745,000	1,490	50,000	695,000	1,390	14.9
Michigan	880	1,866,480	2,121	N.A.***	N.A.	N.A.	-
Minnesota	135	376,650	2,790	101,384	275,256	2,415	3.7
New Jersey	152	83,600	550	80,000	3,600	24	1.05
New Mexico	251	414,652	1,652	51,800	362,852	1,446	8.0
New York	1,613	2,390,466	1,482	N.A.	N.A.	N.A.	-
North Dakota	14	59,500	4,250	26,220	33,280	2,377	2.27
Oregon	33	237,966	7,212	25,000	212,966	6,454	9.52
Pennsylvania	2,500	1,509,000	604	103,855	1,405,145	562	14.53
Tennessee**	168	680,622	4,051	102,256	578,366	3,443	6.66
Texas*	918	1,000,000	1,089	100,000	900,000	980	10.0
Utah	150	1,125,000	7,500	25,000	1,100,000	7,333	45.0
Virginia	187	96,155	514	62,037	34,118	182	1.55
Washington	110	330,000	3,000	70,300	259,700	2,361	4.69
Wisconsin	140	140,000	1,000	24,000	116,000	829	5.83
Totals	27,730	$28,250,907		$ 1,867,042	$22,066,741		
Average			$1,019			$ 877	12.79

N.A. Not available.
* Projections.
** Includes figures for 68 recipients who are on a prior approval restriction.
*** Unable to separate administrative costs of lock-in with those of prior authorization program.

	Adopted Prior to OBRA	Adopted After OBRA
Eyeglasses	5	7
Hearing Aids	3	1
Oxygen	1	1
Laboratory Services	--	1
DME - volume purchasing	0	1
DME - loan closets	2	0
Other	1	1

Clearly, volume purchasing is becoming a more popular method of containing costs. But it should be noted that those items and services which can be volume purchased are only a small portion of the total Medicaid budget. According to HCFA Medicaid program statistics for FY 1983, total nationwide Medicaid expenditures (combined State and Federal) were $32.4 billion. Total national expenditures for laboratory and x-ray services were $183.8 million, which is 0.6 percent of total Medicaid outlays. The program statistics are divided into a limited number of service categories and, because of the differences in the ways states categorize the medical devices that can be volume purchased, these devices may fall under the categories of "home health," "clinic services," or "other care." Although only a portion of the services or items within these categories could be volume purchased, the entire category of "other care" accounted for $935.7 million in FY 1983, which was only 2.9 percent of total Medicaid outlays.

Table 15 shows the kinds of volume purchasing programs currently in existence. In October 1983, Nevada Medicaid began purchasing non-hospital laboratory services through sole-source contracts in two geographic areas--Reno and Las Vegas. The contracts between Nevada Medicaid and the two independent laboratories selected set the reimbursement rate at $0.90 per unit value as defined in the 1974 California Relative Value Studies (CRVS). This was a reduction of $0.20 from the previous rate of $1.10 per unit value for outpatient hospital and physician lab services and an increase from $0.70 per unit value for independent lab services. It should be noted, however, that Nevada ceased paying handling and other service-related charges. Although the sole source contracts covered only non-institutional lab services within the two urban areas, the contract rate of $0.90 per unit value of CRVS was extended to all lab services throughout the state (except for inpatient hospital lab services, which are included in the hospital per diem).

Although not newly authorized by OBRA, states have shown increasing interest in volume purchasing for eyeglasses, hearing aids and durable medical equipment. Table 15 shows the states which use volume purchasing in these areas. The most common is volume purchasing for eyeglasses with limited implementation for other services.

Table 15

KNOWN STATE MEDICAID VOLUME PURCHASING PROGRAMS

State	Eyeglasses	Hearing Aids	Oxygen	Laboratory Services	Durable Medical Equipment: V.P.	Durable Medical Equipment: Loan Closets	Other
Alabama	x						
Alaska		x					
Arkansas	x						
Florida	x	x					
Georgia	x						
Massachusetts	x						
Michigan	x						
Minnesota	x	x	x		x (Wheelchairs)		
Nevada				x			
New Jersey						x	
Ohio	x						
Oregon	x						
South Carolina	x	x					
Utah							rental of oxygen concentrators
Washington	x		x				respiratory therapy
West Virginia						x	
Wisconsin	x						

Why are there so few volume purchase initiatives?

In general, while many states have considered volume purchasing for one or more products, most states are not adopting it--particularly in the newly authorized laboratory service area. Interviews suggest several reasons. First, for some services, geographic dispersion of patients makes reliance on a single supplier difficult. In rural areas, states find that a volume purchasing arrangement would make it too difficult to assure adequate access. Second, some states argued that they faced too few suppliers to create the competition needed to make volume purchasing effective. (Nevada, however, pursued volume purchasing with only two qualified bidders.) Third, and most frequently mentioned, physicians have actively opposed volume purchasing plans. Several states have expended a great deal of effort in developing laboratory volume purchasing proposals, only to see them shot down in the political arena.

Fourth, states find these areas of service a low priority in their cost containment efforts--particularly if solutions involve political conflicts and administrative complexity. And finally, states find simple alternatives available to control costs. As noted elsewhere (see California), it is not necessary to engage in competitive bidding or sole-source purchasing to reduce rates. When it comes to buying some services, straightforward rate reductions may be an easier way to achieve the same spending target. For laboratory services in particular, the 1984 Deficit Reduction Act establishes lower fee schedules for outpatient laboratory services under Medicare and requires Medicaid programs not to exceed Medicare rates. Due to this new law, several states have set aside consideration of volume purchasing plans for laboratory services.

VI. HOME AND COMMUNITY-BASED CARE

Section 2176 of the Omnibus Reconciliation Act authorized the granting of waivers of various Medicaid requirements to allow states to cover home and community-based long-term care services under Medicaid. The purpose of the new authorization was to promote these services as a substitute for nursing home care, without increasing Medicaid costs. Although states were able to cover some home and community-based services prior to OBRA, the law expanded both the scope of services states could cover and states' freedom to target services to selected populations of individuals who would otherwise require institutional long-term care services. This chapter describes the Section 2176 waiver and states' reaction to it, summarizing the findings of Bruce Steinhardt, Brian Burwell, and Christine Brudevold in "Studies Evaluating Medicaid Home and Community-Based Waivers (MPE Working Paper 1.1). (For discussion of other OBRA changes that encourage home and community-based care, see Chapter VII, p. 143.)

Traditionally, states have only been permitted to provide reimbursement for "medically oriented" services under Medicaid. However, the services needed to maintain frail elderly and disabled persons in non-institutional settings are frequently non-medical in nature, such as homemaker/home health aide services, transportation services, respite care, and case management. Further, a substantial number of aged and disabled persons enter nursing homes because the home and community-based services needed to maintain them in non-institutional settings are not available (or because they are eligible for Medicaid only while institutilized. Since the cost of these services is generally less than the cost of nursing home care, this expansion of service coverage under Section 2176 may result in Medicaid program savings if it effectively substitutes for nursing home care within specific target groups.

In addition to expanding the range of services which states may cover under Medicaid, Section 2176 gave the states greater flexibility in deciding who may receive them. In general, all persons who meet financial and categorical criteria are entitled to comparable Medicaid services; Section 2176 allows the states to select waiver recipients with the goal of targeting services to persons who are likely otherwise to require nursing home care. They may thus use criteria which go beyond financial and categorical to include medical, functional, and social factors which put people at risk of nursing home placement. The strength of an applicant's informal support network may, for example, be a factor in deciding whether or not to provide these services. Further, states have expanded flexibility in deciding which waiver services will be provided to which clients, based on an assessment of individual needs.

States are not only allowed to restrict eligibility under the waiver, they may also extend eligibility to people who would otherwise only be eligible for Medicaid if placed in an institution. Under the waiver, states can apply the same income eligibility standard for home and community based care as is used for nursing home care (300 percent of SSI) and can ignore the income of a potential recipient's spouse or parent (waiver the "deeming requirement") after one month, as is done for nursing home residents. The aim in both cases is to eliminate inappropriate incentives to enter institutions.

The Section 2176 waiver program falls somewhere between a research and demonstration effort and adopted policy. Continuation of Federal Financial Participation (FFP) for home and community-based services provided under Medicaid is contingent upon state demonstrations of their cost-effectiveness. Past research strongly suggests that the cost-effectiveness of providing these services is by no means assured.

Even if 2176 waiver services are cost-effective at the individual level, they may result in increased Medicaid expenditures. Individuals who are provided home and community-based services under the waiver may meet nursing home level-of-care criteria, as required by the 2176 legislation, but nevertheless would not have otherwise entered a nursing home. Further, even if a substantial portion of persons provided services under the waiver are diverted from nursing homes, it is possible that the diversion of potential nursing home users will simply make beds available for others who are on the waiting list. While this could lead to program savings over the longer term, the short-term effect would be to simply reduce the unmet demand for nursing home care.

There are also incentives in the Section 2176 program for states to shift individuals being provided home and community-based services in state-funded programs over to the Section 2176 waiver in order to gain FFP for these services. This appears to be particularly true in waiver programs serving the mentally and developmentally disabled, where state-funded community-based programs are generally more developed as a result of the deinstitutionalization policies adopted during the 1970s.

In all likelihood, there will be some Section 2176 waiver programs which prove cost-effective and others which do not. Evaluation of the Section 2176 waiver program will therefore attempt to identify those program, service, and client-oriented factors which are associated with cost-effectiveness.

The following discussion represents a first step in that evaluation. Based on information contained in state waiver applications, and a mail survey (and follow-up phone survey) of operational programs in the summer of 1984, the following describes program characteristics and presents the states' estimates of the waiver programs' impact on spending.

How did states respond to the Section 2176 authority?

As of November 1, 1984, 47 states had submitted 135 waiver applications, of which 78 were approved, 31 were under review, 13 had been withdrawn, and 13 had been denied. Of the 78 approved waivers, 11 are so-called model waivers, serving no more than 50 people and the remaining 67 are regular section 2176 waivers.

All applications for a Section 2176 waiver must specify one or more target populations. Since the two major users of nursing home care* paid by Medicaid are the impaired elderly and the mentally retarded, it is no surprise that these groups are the two primary target populations. Table 16 and Figures 9 and 10 provide data on the 67 waivers approved as of November 1, 1984. Thirty-four included the developmentally disabled as a target group, and 37 included the aged as a target group (several programs designated both populations as target groups). Other groups include the chronically mentally ill, the non-elderly physically disabled, persons with developmental disabilities other than mental retardation (e.g., epilepsy, cerebral palsy, autism), and the blind.

States may also restrict waiver program eligibility by cash assistance status. For example, states with medically needy programs do not have to extend eligibility for the waiver program to persons who are not receiving cash assistance. Of the 48 approved waiver programs in medically needy states, 12 programs do not extend eligibility to the medically needy.

States may also restrict eligibility for the Section 2176 waiver to certain geographical areas. This is accomplished through a waiver of statewideness. Of the 67 approved waivers, 46 also received a waiver of statewideness to allow for the provision of home and community-based services on less than a statewide basis. However, of those programs with waivers of statewideness, 21 plan to eventually phase in home and community-based services statewide.

As noted above, Section 2176 also allows states to apply the same special Medicaid income eligibility rules to waiver recipients as are used for nursing home recipients. Specifically, states may extend eligibility for home and community-based services on the same terms as eligibility for nursing homes--that is, to people with incomes above the SSI standard but less than 300 percent of SSI; and to people who would not qualify for Medicaid where income of a spouse or parent was "deemed" available to them.** Deeming requirements for SSI may also be waived. Thirty-four of the 67 approved programs have used these provisions: 22 waiving deeming and using the 300 percent income option; 8 waiving deeming rules; and 4 using only the 300 percent income option.

What services have states offered in waiver programs?

States have considerable flexibility in determining what services to provide under the waiver. The interim regulations specifically identified seven services which could be provided under the waiver:

---

*Although Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) are not nursing homes, for ease of exposition the term nursing homes is used to refer to SNF, ICF and ICF/MR levels of care.

**These actions originally, but no longer, required specific waivers. However, States must specify the income eligibility rules for waiver recipients if they wish to use the deeming or "300 percent" rules.

Table 16

Section 2176 Waiver Programs Approved As of November 1, 198-

State	Target Group	Effective Date	Renewal Date
Oregon (1)	A/D-DD/MI	12/81	12/84
Montana (2)	DD	12/81	12/84
Iowa	A/D	1/82	1/85
Louisiana	A/D-DD	1/82	1/85
Kansas	A/D-DD	3/82	3/85
Florida	A/DD	4/82	4/85
Florida	A	4/82	4/85
Missouri	A	4/82	4/85
Vermont	DD/MI	4/82	4/85
South Dakota	DD	6/82	6/85
Virginia	A/D	6/82	6/85
California	DD	7/82	7/85
Colorado	A/D	7/82	7/85
Minnesota	A	7/82	7/85
Missouri	A	7/82	7/85
North Carolina	A/D	7/82	7/85
Nevada	DD	7/82	7/85
West Virginia	A/D-DD	7/82	7/85
Utah	A/D-DD/MI	9/82	9/85
Alabama	DD	10/82	10/85
Colorado	DD/MI	10/82	10/85
Connecticut	A/D	10/82	10/85
New Jersey	DD	10/82	10/85
California (2)	MI	12/82	12/85
New York (3)	A/D	12/82	12/85
South Carolina	A/D	1/83	1/86
Texas	A	1/83	1/86
Washington	A/D	1/83	1/86
North Dakota	DD	4/83	4/86
California	A	7/83	7/86
California	D	7/83	7/86
Delaware	DD	7/83	7/86
Hawaii	DD	7/83	7/86
Illinois	A/D	7/83	7/86
Kentucky	A/D	7/83	7/86
Kentucky	DD	7/83	7/86
Massachusetts	A	7/83	7/86
Maine	DD	7/83	7/86
Montana	A/D-DD	7/83	7/86
North Carolina	DD	7/83	7/86
New Mexico	A/D	7/83	7/86
New Mexico (4)	DD	7/83	7/86
Pennsylvania	DD	7/83	7/86
Pennsylvania	DD	7/83	7/86
Rhode Island	DD	7/83	7/86
Rhode Island	MI	7/83	7/86
Hawaii	A/D	8/83	8/86
Hawaii	A/D	8/83	8/86
New Hampshire	DD	9/83	9/86
New Jersey	A/D	10/83	10/86
North Dakota (4)	A/D	10/83	10/86
Wisconsin	DD	10/83	10/86
Illinois	DD	12/83	12/86
Washington	DD	12/83	12/86
Kentucky (4)	A/D	1/84	1/87
Massachusetts (4)	A	1/84	1/87
Massachusetts (4)	DD	1/84	1/87
Missouri (4)	D	1/84	1/87
Maryland	DD	2/84	2/87
Nebraska (4)	DD	4/84	4/87
Tennessee (4)	A/D	6/84	6/87
Minnesota (4)	DD	7/84	7/87
Ohio (4)	A/D	7/84	7/87
New Hampshire (4)	A/D	7/84	7/87
Indiana (4)	A	9/84	9/87
Georgia (5)	A/D	10/81	Renewed to 11/87
Rhode Island	A/D	1/82	Renewed to 1/88

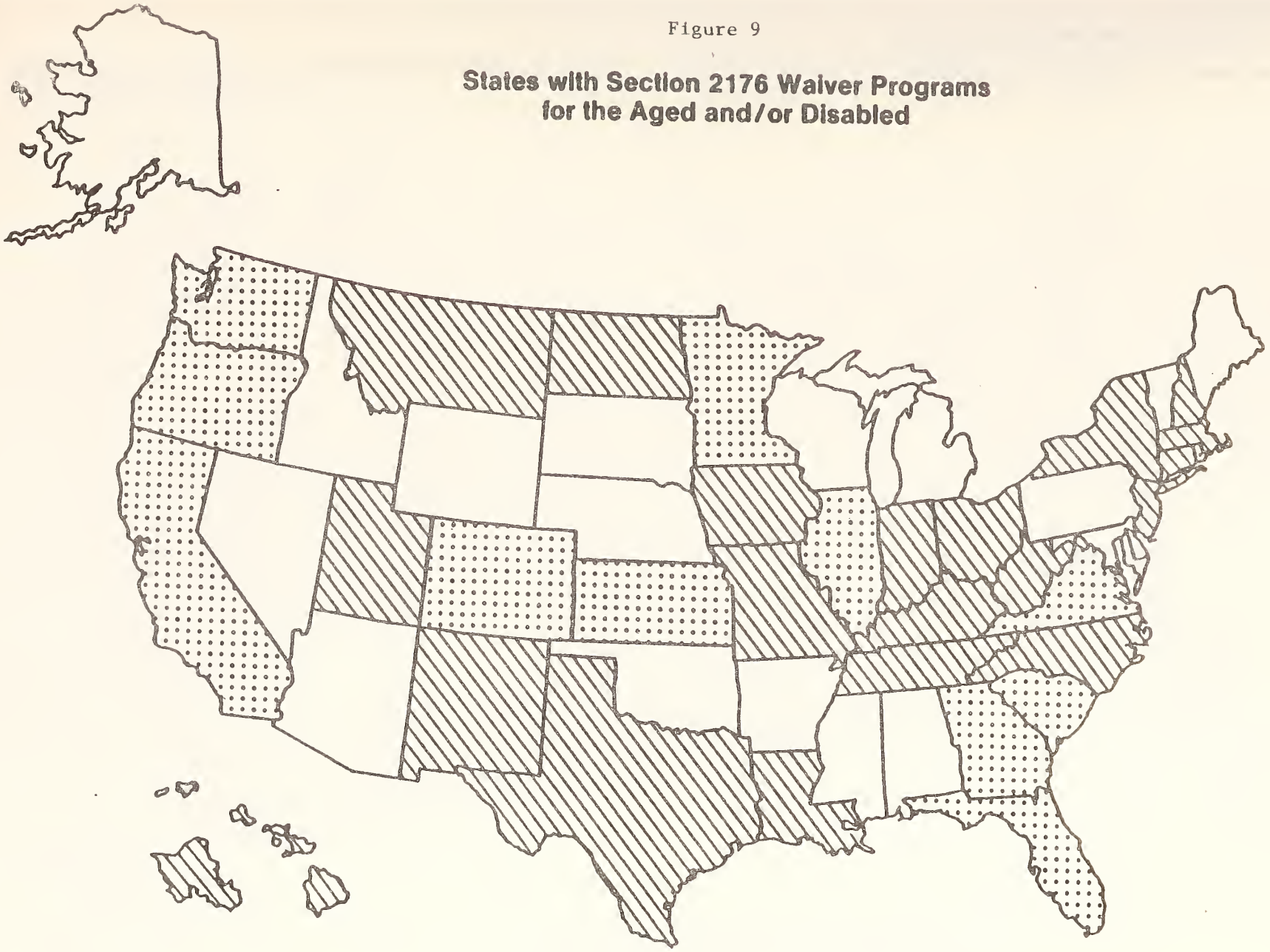
(1) Oregon waiver extended for a 45 day period from expiration date.
(2) Program to be discontinued
(3) Part of this waiver was effective 1/83
(4) Not implemented as of November 1, 198-
(5) Substantial changes made, considered by HCFA to be a new waiver.

Target Groups: A = Aged, D = Disabled, DD = Developmentally Disabled, MI = Mentally Ill, A/D = Aged and Disabled

Source: HCFA Bureau of Eligibility, Reimbursement and Coverage

Figure 9

States with Section 2176 Waiver Programs for the Aged and/or Disabled



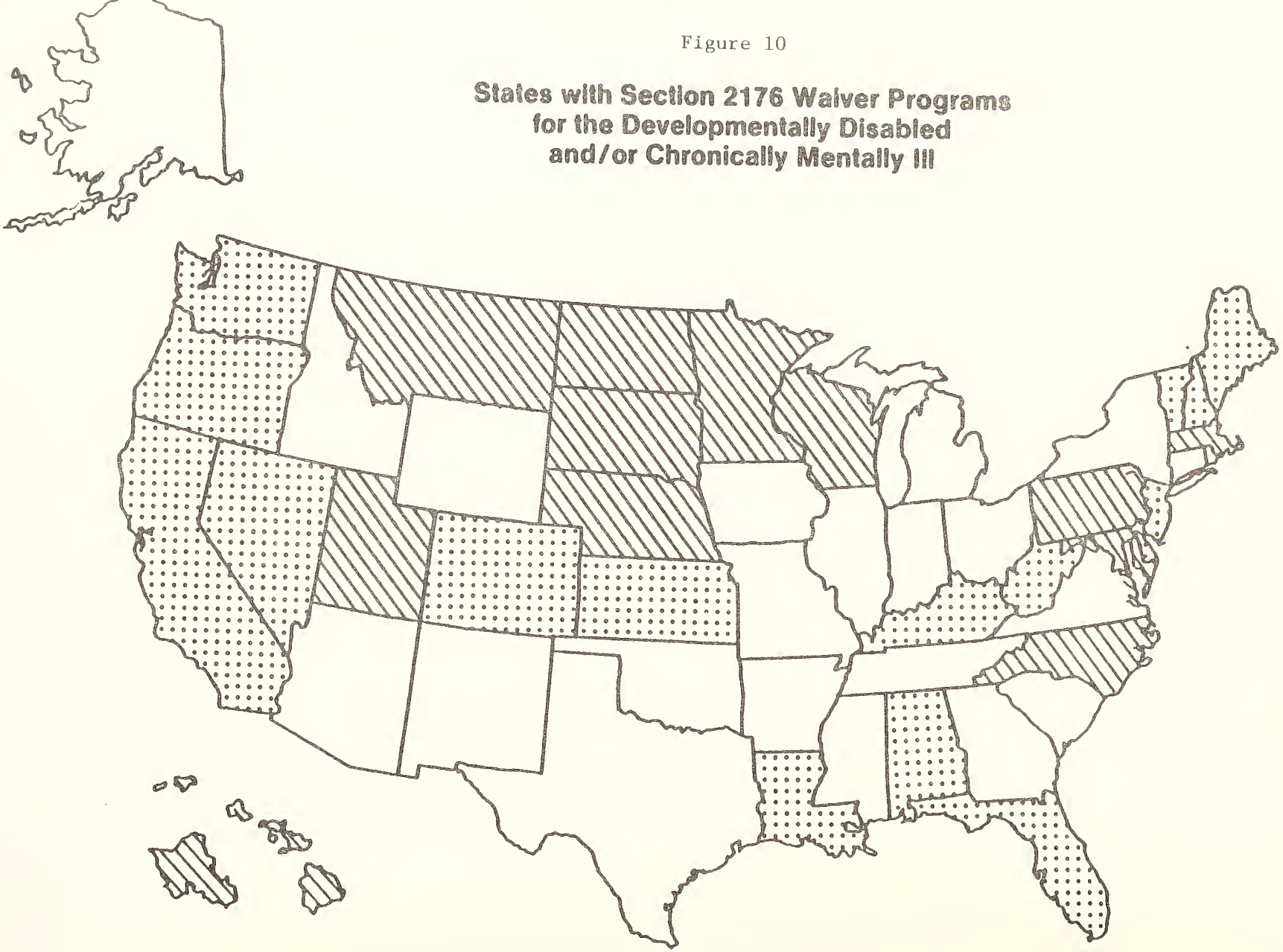
Data are as of November 1, 1984
Source: HCFA Office of Research and Demonstrations

Waiver operational in at least 50% of all counties

Waiver operational in less than 50% of all counties

Figure 10

States with Section 2176 Waiver Programs for the Developmentally Disabled and/or Chronically Mentally Ill



Data are as of November 1, 1984
Source: HCFA Office of Research and Demonstrations

Waiver operational in at least 50% of all counties

Waiver operational in less than 50% of all counties

- o Case Management
- o Homemaker Services
- o Home Health Aide Services
- o Personal Care Services
- o Adult Day Care Services
- o Habilitation Services
- o Respite Care Services

However, the Department has given states a great deal of latitude in specifically defining these services, since the overall objective of the 2176 waiver is to give states the flexibility they need to devise cost-effective alternatives to institutional care. In addition, states may provide other services which they can show are cost effective substitutes for institutional care. Consequently, a great deal of variation exists across states in how services are provided and defined. It should also be noted that although personal care and adult day care services have long been eligible for Medicaid reimbursement as state options, they were included as waiver services in order to allow states the flexibility to provide alternative definitions of these services, or to alter restrictions on their amount, duration or scope for waiver program clients only. For example, under Medicaid regulations, personal care services cannot be provided by a recipient's relative. A few states have used the waiver to allow family members to become eligible providers of personal care services. Another example is that some states have included home health aide services under the waiver because the number of visits or payment levels under the Medicaid state plan were too restrictive for serving the more intensive and/or longer term needs of the waiver program clientele. Also, some states have elected to provide these services under the restricted eligibility criteria permitted by the 2176 waiver.

There are only a few restrictions on services which cannot be covered under the waiver. The regulations specifically prohibit coverage of room and board. Since most waiver recipients receive full SSI benefits (and often state supplemental payments) outside of a nursing home, SSI/SSP is considered the proper funding source for the basic shelter and living needs of waiver clients. In addition, reimbursement is not permitted for any services which are provided to residents of institutions or are not necessary to prevent institutionalization.

A summary of approved waiver services by major target groups is presented in Table 17. Since the 2176 legislation requires that all applicants undergo a comprehensive assessment, it is not surprising that case management is the most frequently requested waiver service. Seventy-seven percent of all programs targeting the Aged/Disabled offer case management, and 86% of all DD/MI programs offer this service.

As might be expected, programs which are targeted to the aged and disabled offer different services than programs targeted to the mentally and developmentally disabled. The services most frequently provided in waiver programs serving the aged and disabled are Respite Care, Adult Day Health, and Homemaker Services. Programs for the mentally and developmentally disabled most often provide Habilitation Services and Respite Care. Habilitation services is an umbrella term for a wide variety of day program services, daily living skills training, and other supportive services which are needed to help maintain developmentally disabled persons in non-institutional settings.

Table 17

Waiver Programs with Approved Services
by Target Population

Waiver Services	Aged/Disabled (N = 39)		DD/MI (N = 35)	
	N	%	N	%
Case Management	30	77%	30	86%
Homemaker	26	67	10	29
Home Health Aide	12	31	6	17
Personal Care	17	44	10	29
Adult Day Health	19	49	10	29
Habilitation	1	3	28	80
Respite Care	26	67	23	66
Other				
Transportation	14	36	15	43
Emergency Response	9	23	1	3
Structural Modifications	11	28	10	29
Therapy	10	26	10	29
In-home Nurse	10	26	5	14
Miscellaneous	28	72	24	69

Sources: HCFA Waiver Files and survey of Section 2176 waiver programs.

What impact have Section 2176 waivers had on people?

As of June 1, 1984, at least 50,000 persons had been provided home and community-based services under the Section 2176 waiver authority. This amounts to about 3.5 percent of the annual number of nursing home recipients on Medicaid and is close to the projected total caseload across all implemented waiver programs. Five programs accounted for 60 percent of total persons served as of this date.

Table 18 displays the total number of persons admitted to each of the active waiver programs through the June 1, 1984. (In some cases, a recent census count of active clients was reported, which under states the total number of individuals served to date.) The Florida program serving 3,320 aged/disabled and 6,543 developmentally disabled persons and the Illinois program serving 6,965 aged/disabled recipients have the largest number of clients served to date. Seventeen programs have served 50 or fewer persons, while 13 have served 1000 or more. Most of the largest waiver programs serve the aged/disabled target groups. Of the total reported enrollment in waiver programs, 53% were reported to be aged and/or disabled, 32% developmentally disabled and/or mentally ill and 14% were not reported by category (data not displayed).

Table 18

Total Number of Persons Served Through June 1, 1984
by Target Group and Waiver Program

Waiver Program			Date Implemented		Number of Persons Served	
Waivers for the Aged and/or Disabled						
IL	1		7/83		6,965	
GA			10/81	(1)	4,748	
FL	1+2	**	4/82		3,320	*
NY			12/82	(1)	3,078	
CO	1		2/83		2,194	
CA	3		7/83	(1)	2,074	
MO	1		7/82		691	
CT			6/83		682	
SC			3/83		675	
MN	1		7/82		648	
RI	1		10/82		623	
VA			11/82		611	
WA	1		3/83		357	
LA		***	4/82		346	
NH	1		8/83		265	
NJ	2		11/83		245	
NC	1		11/83		219	
LA			1/82		178	
WV		***	12/82		168	
KY	2		7/83		129	(3)
CA	4		7/83	(4)	112	
HI	3		8/83		69	
TX			1/83		44	
MO	2		7/82		30	(2)
MA	1		5/84		13	
HI	2		5/84		12	
TOTAL A/D					28,496	
Waivers for the developmentally disabled and mentally ill						
FL	1	**	4/82		6,543	*
AL			10/82		1,900	
LA		***	7/82		1,731	
NJ	1		10/83		1,320	
CO	2		9/83		1,061	
CA	1		11/82		880	
WA	2		12/83		768	*
VT			7/82		612	
NV			7/82		494	
SD			6/82		447	
KY	1		4/83		363	
NH	1		9/83		332	
ND	1		4/83		200	
RI	3		7/83		114	
MI			11/83		93	
MD			2/84		78	
RI	2		7/83		65	
PA	1		7/83		59	
PA	2		7/83		55	
NC	2		7/83		54	
DE			7/83		48	
MT	1		12/81		45	(2)
HI	1		10/83		24	
WV		***	3/84		17	
WI			10/83		10	
IL	2		7/83		NA	
TOTAL DD/MI					17,313	
Combined target groups						
OR			12/82		6,768	(5)
KS			7/82		555	
MT	2		9/83		178	
UT			11/83		7	
TOTAL COMBINED					7,508	

Source: Survey of 2176 waiver programs

Notes: * Program client census reported.
** FL 1 waiver serves both A and DD groups;
FL 2 serves aged persons also served in FL 1.
*** Program serves combined target groups;
enrollment data reported separately for each.
1. Converted from an 1115 waiver demonstration.
2. Program discontinued by State.
3. Persons served as of 7/18/84.
4. Operated from 7/82 to 7/83 as a State funded program.
5. Includes A/D and MI groups; excludes DD group.

Mentally retarded persons are a particularly important target group. While recipients of ICF-MR care comprise about 10 percent of the total Medicaid nursing home population, persons diverted or deinstitutionalized from ICF-MR level of care comprise about one-third of the current waiver program caseload.

In state waiver applications, the total number of home and community based recipients projected to be served across all approved programs in their first three years are 68,174, 84,754, and 104,688, respectively. There is wide variation in the size of the expected first year caseloads, ranging from 50 or less in six programs to over 1,000 in 14 programs.

The states' projected impact of the waiver programs on total institutional recipients (for levels of care affected by the waiver programs) are reductions of 54,868, 69,870 and 86,473 in years 1, 2 and 3 respectively. Relative to expected numbers without the waiver programs, these are declines of 5.2%, 6.4% and 7.7%, respectively. The percentage reductions in nursing home recipients by level of care (where the application showed recipients by level of cre) are proportionately greater for ICF/MR; for example, 11.4% versus 3.9% and 4.3% for SNF and ICF, respectively in year one. However, the net decrease in recipients is greater for SNF and ICF than for ICF/MR (14,724 and 19,869 versus 10,807).

The impact of the waiver program on total LTC recipients (eligible nursing home, waiver and other community-based alternatives) are increases of 13,066 (1.1%), 14,903 (1.2%) and 18,261 (1.5%). Fifteen states expect the waiver to increase the size of the total LTC population; however, seventy-five percent of the increase is due to LTC population expansions in two of the earliest approved waivers: Louisiana and Oregon. The net increases reflect several factors: serving individuals who were previously deinstitutionalized or diverted into state-funded community programs; early intervention for persons whose institutional use would occur in a subsequent year; the recognition that targeting criteria might not result in one-for-one reduction in nursing home recipients; and use of the waiver to reduce the length and cost of alternate placement days in acute care facilities.

How will Section 2176 waiver programs affect Medicaid spending?

There are two kinds of information on the impact of Home and Community Based Waivers on Medicaid spending: projections from waiver applications and early evidence from annual reports. While the applications provide interesting information on how states expect the programs to work, they have not been particularly reliable as predictors of actual outcomes.

In waiver applications, states project waivered services to add $302.5 million to expenditures for community-based care in year one, increasing to $486.1 million in year two and $713.2 million in year three. In aggregate, the approved waiver programs are projected to reduce expenditures for nursing home care by $705.9 million (6.1% of expenditures for covered levels) in year one (Table 19). Over 40% of the savings are in ICF/MR services, with the remainder of savings split almost equally between SNF and ICF care. The ICF/MR reduction represents a decrease of 9.8% in ICF/MR expenditures in waiver states, while the SNF and ICF projected savings are about 5%.

Table 19

Projected Waiver Program Impact on LTC Expenditures
By Level of Care and Waiver Year

LEVEL OF CARE	YEAR 1		YEAR 2		YEAR 3	
	$ (1,000s)	%	$ (1,000s)	%	$ (1,000s)	%
ALL	-403,450	-3.6%	-556,600	-4.4%	-703,593	-5.1%
INSTITUTIONAL	-705,917	-6.5%	-1,042,797	-8.7%	-1,416,816	-10.7%
SNF	-157,664	-4.8%	-200,635	-5.6%	-262,804	-6.7%
ICF	-170,454	-4.5%	-225,136	-5.4%	-294,874	-6.4%
ICF-MR	-305,025	-9.8%	-518,364	-14.9%	-728,447	-18.9%
COMMUNITY-BASED	302,466	57.6%	486,198	85.1%	713,223	112.9%

Notes: Impacts shown are relative to total projected expenditures without the waiver for levels of care affected by the waivers across all waiver States.

Expenditures by institutional level of care were unavailable for several programs; therefore, the sum across levels of care is less than the institutional total.

Source: HCFA waiver files

Total projected savings from the waiver program are $403.5 million in year one, $556.6 million in year two and $703.6 million in year three. These represent percentage savings for covered levels of care (including other community-based alternative care) of 3.6% for year one, 4.4% for year two and 5.1% for the third year. Projected savings for individual programs ranges widely across states.

These estimates reflect waiver requirements that states report the number of long-term care recipients and expenditures with and without the waiver and show that per capita costs will be no higher under the waiver. For purposes of the cost comparison, per capita expenditures are defined as expenditures per recipient who would be served without the waiver. Instead of dividing projected expenditures with and without the waiver by the number of recipients expected with and without the waiver, respectively, the total costs with and without the waiver are both divided by the total number of recipients who would be served without the waiver.

This choice of per capita calculation is necessary to assure that total costs are lower under the waiver even if the population getting service increases. To further assure spending control, however, states have been required to: (1) show a one-for-one correspondence between waiver recipients and the reduction in nursing home recipients; or (2) substantiate the rationale for expanding the total number of nursing home and community-based recipients under the program.

Nonetheless, the waiver formula is not an absolute assurance of lower costs. First and foremost, the formula is predicated on projections and assumptions which may or may not be accurate. Another important limitation to the waiver savings formula is that it considers only Medicaid expenditures for institutional and home and community-based long-term care costs. The cost comparison excludes the costs of non-LTC services provided to waiver eligibles, such as prescription drugs and physician services, and "spill-over" costs to other Federal programs, like Medicare, SSI, food stamps, and housing programs.

States took five basic approaches in projecting cost savings: closing facilities, closing (decertifying) beds, reducing the need to build new beds to meet future or pent-up demand, reducing hospital back-ups, or simply reducing Medicaid use of existing beds. The Aged/Disabled and DD/MI programs took somewhat different approaches to achieving cost savings and several predicated their projections using several methods. Reducing the need for bed increases was the most frequent source of savings. It was used as a rationale in two-thirds of both types of programs. Almost a third of the DD/MI programs expected to reduce nursing home use by closing beds or facilities, usually in concert with deinstitutionalization of the residents. The aged/disabled programs were more likely to foresee cost savings in reducing hospital back-ups, although only two explicitly included reduced hospital stays in their waiver formulas.

As noted above, preliminary data from waiver applications suggest that projections made in waiver applications are not reliable estimates of real program costs or savings. Due to delays in program implementation and lags in

submission of acceptable annual reports on long-term care expenditures under the waiver program, data on the cost impacts of the program are extremely sketchy at this time. As of October, 1984, only sixteen annual reports for 12 programs had been accepted by HCFA. One state was dropped from the analysis because payment lags resulted in no information being reported on the numbers of waiver recipients and their costs. Several other first year reports most likely under-reported the actual numbers of recipients and their costs due to claims payment lags.

The first conclusion drawn from the analysis of the 15 annual reports on 11 programs was that the original waiver formula projections were not particularly accurate. Nine of the 11 erred by more than 10% in projecting the number of first year waiver recipients, with eight serving fewer waiver recipients than expected. Likewise, actual expenditures per waiver recipient were almost always lower than projected, probably due in large measure to less than a full year of service for recipients and to claims payment lags. For institutional care, projections of cost per nursing home recipient were also off the mark by at least 5 percent in most of the cases.

The second major conclusion of the analysis was that at least some of the programs generated net Medicaid long-term care savings relative to the states' estimates of what costs would have been without the waivers. In order to provide a more accurate estimate of waiver program savings, states' projections of costs without the waiver were adjusted to eliminate errors in predicting actual cost per nursing home recipient and to remove artificial savings (or expenditure increases) in levels of care largely unaffected by the waiver or greater than could be accounted for by the numbers of waiver recipients who were diverted/deinstitutionalized.

Compared to the adjusted projections of costs without the waivers, actual costs under the waiver showed savings for eight of the 11 programs. All four programs serving the developmentally disabled (mostly or entirely mentally retarded persons) showed substantial savings, ranging from 5% to 20% of the adjusted projected costs without the waivers. The other seven programs, serving primarily the impaired elderly, achieved savings of less than 2% in four cases and increased costs (of 0.3% or less) due to the waivers in three cases. Because of the limitations of using waiver formulas to estimate savings, the newness of the programs, and the unrepresentativeness of the programs with accepted reports, these findings should not be taken as an indicator of aggregate cost savings for the Home and Community-Based Care program.

What problems have states had implementing their programs?

Upon approval of their waiver applications, many states were ill-prepared to actually implement a Section 2176 waiver program. Some of the more common problems encountered by states during program implementation were:

- **Interagency Coordination**. Establishing the division of administrative responsibilities between the state Medicaid agency and the specialty agency often required extensive negotiation. This was the most common implementation problem reported by states.

- **Establishing Waiver Services.** Delays were encountered in identifying appropriate providers of waiver services, in negotiating provider agreements, and in certifying providers for Medicaid participation.

- **Establishing Reimbursement Methods.** Many states had to develop rate structures for waiver services from scratch, and negotiate these rate structures with providers who had no prior experience in Medicaid.

- **Implementing Targeting Criteria.** Although those persons who were involved in writing the waiver application were aware of the need to target services in a cost-effective manner, many persons who later became involved in the waiver program, such as case managers and providers, had a more difficult time understanding who was eligible to receive waiver services and who was not.

- **Applying Institutional Financial Eligibility Criteria.** States had particular difficulty in operationalizing the expanded eligibility options under the waiver, i.e., the option to waive deeming requirements and to include individuals with incomes up to 300 percent of the SSI Federal payment level.

- **Fulfilling HCFA Data Reporting Requirements.** Many states had difficulty setting up information systems which were adequate to comply with HCFA data reporting requirements for the Section 2176 waiver.

- **State Budgetary Problems.** In a few instances, implementation delays were related to difficulties in securing funding for the state share of waiver services. In some cases, negotiations occurred over whether the state share would come from the Medicaid agency budget, or from the budget of the agency with programmatic responsibility for the waiver program (e.g., the state mental retardation agency).

State difficulties in establishing reimbursement and payment systems, and in developing the information systems to comply with HCFA reporting requirements initially impeded the Department's efforts to monitor program expenditures. However, several monitoring systems have been installed to track spending and ensure compliance with program requirements.

VII. FINANCIAL INCENTIVES FOR FAMILY CARE

As part of a general effort to contain government spending on long-term care, policymakers have become increasingly interested in supporting and encouraging family-provided, i.e., informal, care-giving to the impaired elderly. In response, a study was conducted to review current knowledge on the role of the family in providing care, to examine the way current Medicaid and SSI rules affect families' willingness to provide care, to assess changes in Medicaid to promote family support (paying family members as Medicaid providers and requiring financial contributions from adult children of Medicaid-financed nursing home residents), and to describe existing tax incentives to promote the elderly's independence or to promote family care. This chapter summarizes the discussion of these issues presented in Brian Burwell, Christine Brudevold, and Gail Jones, "Financial Incentives for Family Care," MPE Working Paper 2.1.

What role do families now play in serving the impaired elderly?

Surveys have consistently shown that informal caregivers provide the vast majority of long-term care services (see Figure 11). The research indicates that between 70 to 80 percent of the impaired elderly population rely solely on informal (unpaid) supports for assistance with activities of daily living. Another 10 to 20 percent rely on a combination of informal and formal (paid) providers, while generally only about 10 percent of the impaired elderly rely solely on the formal care network. Further, preliminary data from the 1982 Long-Term Care Survey indicate that approximately three-fourths of all services purchased from the formal care network are purchased with private funds; only 21 percent of formally provided care was government financed. No evidence has emerged which suggests that the level of care provided by informal caregivers has declined in response to the growth in public expenditures for long-term care services.

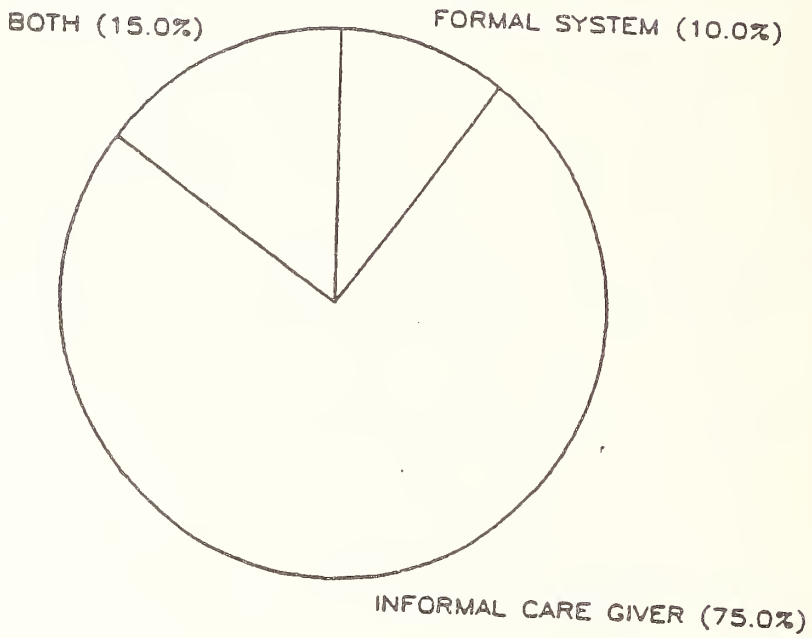
Only one study was identified that examined Medicaid recipients' use of informal care. The study found that the Medicaid population had made greater use of formally provided services and less use of informal services than the community sample. The authors did not know whether to attribute this finding to (1) greater impairment among the Medicaid sample; (2) a less capable informal support system; or (3) greater access to publicly funded home care services for Medicaid clients.

The literature suggests that policy makers concerned with family care should keep in mind the following: First, current policies do not appear to be encouraging families to abandon their elderly relatives when they need care. Second, public payment to families to encourage care may not save government money. It may simply pay for services that would have been provided free of charge. However, these payments may reduce the burden of providing care and improve the quality of life for the elderly and the caregiver.

Third, some savings may be possible even if substitution of formal for informal care occurs. It may be appropriate to relieve family caregivers (e.g., by financing respite care) for short periods so that they will be

Figure 11

Sources of Long Term Care for Elderly



willing to provide care over a long period, rather than place elderly relatives in nursing homes. The difference between short-term and long-term substitution must therefore be recognized.

How do SSI and Medicaid policies discourage family care?

Several of Medicaid's current eligibility policies--some associated with SSI--may affect family members' willingness to care for their elderly relatives. The following summarizes their effects:

SSI deeming policies. Deeming is a provision under which some of the income of a responsible relative living in the same household as the applicant is considered to be available to the SSI applicant for purposes of determining the applicant's eligibility and benefits. It does not matter whether the income of the other person is actually available/ contributed to the applicant or not. This responsible relative is defined to be a spouse, a parent for a child, or an essential person.

Deeming in SSI continues only so long as parties reside in the same household. Deeming rules are no longer applied with the first full month that the SSI recipient is absent, unless the absence is temporary. This time period is extended to six months if both members of the couple are SSI-eligible. If spouses cease to live together because of the institutionalization of one spouse, mutual consideration of income ceases with the month after the month in which separation occurs.

SSI deeming policies can create situations where a spouse or disabled child is ineligible for SSI, and therefore Medicaid, while living at home, but is eligible if placed in a nursing home. It is often claimed that these deeming policies create incentives to institutionalize an elderly spouse or a retarded child in order to reduce the financial burden upon the family.

209(b) States--i.e., states that adopt eligibility policies more restrictive than SSI--have the authority to establish more restrictive deeming provisions than those established under the SSI program, and 7 of the 14 209(b) states have chosen to do this. Some states require deeming of income even when a spouse or parent is institutionalized. This reduces part of the bias for individuals to enter institutions as the eligibility requirements are the same for an individual in the community as in a nursing home. However, the lack of Medicaid reimbursed services to support individuals in the community make it difficult for many families to care for the disabled in the home.

Transfer of assets policies. Financial eligibility for SSI, and therefore Medicaid, include both income and assets criteria. The SSI program allows a couple to retain $2,250 in reserve resources and an individual $1,500, but imposes no limits on the value of the home. Since many aged recipients live on low incomes but have built up their assets over their years, SSI eligibility policies create an incentive for aged individuals to transfer their available assets to their children in order to become Medicaid eligible.

However, recent legislation has tightened up transfer of assets policies. The Omnibus Reconciliation Act of 1981 restricted the opportunity of individuals to transfer resources to attain SSI or Medicaid eligibility. New regulations were enacted to prevent Medicaid applicants or recipients from disposing of resources at less than fair market value during the 24-month period preceding application for eligibility or claim filing. These regulations prohibit individuals from disposing of resources in anticipation of entering an institution and having all expenses paid by Medicaid.

While this may increase the initial amount that individuals contribute toward their care, it may also serve as a disincentive for families to aid in the care of their disabled or elderly. Many family members provide in-home services, care and attention to an aged or disabled person in an often unspoken agreement of reciprocity, wherein care provided by adult children will be later compensated with an inheritance. The regulations specify that care and services received in exchange for a resource may be considered as compensation only so long as a "legal contract" exists. The process of quantifying family care/responsibility into a formal contract may act as a disincentive for families who under other circumstances would be willing to provide informal care.

Lien laws. Prior to 1982, states were prohibited from imposing liens against any recipient's property prior to his or her death for Medicaid claims paid on the individual's behalf, except when the lien was the direct result of a court judgment for claims incorrectly paid. However, under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), the ability of State Medicaid agencies to extract the equity in a person's home to offset Medicaid reimbursements was enhanced. Under the provisions of TEFRA, if a recipient is an inpatient in a SNF, ICF, or other long-term care facility, and the state determines that the individual cannot reasonably be expected to be discharged and return home, the state is allowed to place a lien on the property of the individual so long as there are no children or spouse living in the home.

It does not appear that many states have utilized this TEFRA option to impose liens on the homes of nursing home recipients on Medicaid. One would probably assume that extensive use of lien laws would be a significant deterrent to institutionalization, if elderly persons knew that the equity in their home could be extracted by the state in order to pay for nursing home care. In some cases, adult children might be discouraged from seeking nursing home placement if they thought it would jeopardize the eventual inheritance of their parent's real property.

Reduction in SSI benefit for shared living arrangements. Another provision of SSI eligibility policy which many have claimed serves as a disincentive for family care is the one-third reduction in SSI benefits if the applicant lives in the household of another. Thus, if an aged parent lives with his or her adult children, the basic Federal SSI benefit in 1983 would be reduced from $294 per month to $196 per month. If the aged parent has other income of between $196 and $294, he or she would be ineligible for SSI at all, and, therefore, also ineligible for Medicaid. This reduction in the SSI benefit for shared living arrangements has been frequently cited as another incentive to adult children not to take an impaired elderly parent into their own home.

SSI state supplementation rules. Many states supplement Federal SSI payments with state funds (State Supplemental Payments or SSP). Of the 39 states with programs, nine exclude eligibility to the SSP program if individuals live independently. Further, coverage is limited to individuals who live in a residential type care facility in seven of these states. As eligibility for both the SSP program (and also for Medicaid in two of these states) requires a residential facility living arrangement, SSP may encourage people to enter long-term care facilities rather than remain at home or with relatives. However, these supplements may simply cover the costs of obtaining needed formal supports. In ten states, SSP goes further and provides direct support for in-home services through so-called "special needs" benefits.

Four states (Alaska, Connecticut, Idaho, and New Hampshire) have specific family responsibility regulations requiring adult children to assume responsibility for their parents in order to become eligible for SSP. If these regulations are actually enforced, the program would require adult children to contribute to the care of their parents, and eligibility would technically be restricted to individuals who either do not have children or who have children with limited income and resources. Non-compliance on the part of adult children is a common problem and because most states are reluctant to refer cases to the courts, the regulations are usually not actively enforced. Thirteen states have specific spouse-for-spouse or parent-for-child regulations, and six states have lien and recovery laws similar to those discussed earlier which enable them to recover dollars expended through SSP.

What Medicaid policies encourage family care?

Many impaired people who could remain at home if care were provided are unable to qualify for Medicaid unless they enter long-term care institutions and become eligible through higher income limits, waiver of deeming requirements, or spend-down. In addition, the limited coverage of home-care services both in scope and amount is inadequate to meet the needs of many individuals.

Due to rapidly escalating costs of care associated with institutionalized Medicaid recipients, new policies have been initiated to address these problems. These policy initiatives, which are designed to substitute community-based services for more costly institutional care include:

- Section 2176 Home- and Community-Based Waivers
- Section 134 Option
- Katie Beckett Waivers
- Section 2176 Model Waiver Programs

As a result of these programs, options are now available which make it possible for more extensive community care programs and support networks to be developed. Section 2176 was described in depth in Chapter VI. Briefly, the other three programs are:

Section 134 option. This option, created by Section 134 of the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248), allows a state to provide Medicaid coverage to those children under age 19, living at home, who qualify as disabled under Section 1614(a) of the Social Security Act who would

be eligible for SSI or a State Supplemental Payment if residing in a medical institution. States electing this option must cover all disabled children on a statewide basis who meet the following criteria:

- the child requires the level of care provided in a hospital, skilled nursing facility, or intermediate care facility;
- it is appropriate to provide the care for the child outside of such an institution;
- the estimated cost of care at home is no more expensive than the estimated cost of such institutional care; and
- the child would be eligible for SSI or a state supplemental payment if in an institution.

The Section 134 option has been chosen by only eight states (and the Northern Marianna Islands). So far, state response to this program has been weak. The high costs associated with serving this population and the fear that the program will attract a large number of previously unserved individuals has been a strong deterrent to adding the program to the State Medicaid plan.

The Katie Beckett waivers. These waivers provide states an interim approach in assisting on a person-by-person basis both children and adults who would be institutionalized if they did not receive home and community-based care. This option permits state Medicaid agencies to submit a request for waivers of deeming of income and resources rules for a particular individual. The waiver makes it easier for families to care for their members at home, particularly in those states which have not yet implemented broader solutions to home and community-based care.

Each individual waiver request is reviewed by a special intradepartmental board established by the Secretary. The tenure of the board has been twice extended and is currently in effect through December 31, 1984. The board's determinations apply in any state, include 209(b) states, which use SSI deeming rules. The waiver of deeming is reviewed on a regular basis to determine if the individual is still eligible. The waiver remains in effect as long as all conditions remain the same.

Katie Beckett waivers have been submitted by 19 states as of June 15, 1984. These 19 states have submitted a total of 176 individual waiver requests with approximately one-half of those waivers (91) being approved. Each of the 19 states submitting waiver requests has had at least one waiver approved. A state tends to use this option when no other options are immediately available. It is used to provide medical assistance to those persons who may not be covered under other programs but who need this assistance to avoid institutionalization.

Section 2176 Model Waiver Programs. States are also permitted to target particular individuals, using Section 2176 model waiver authority. States may request a model waiver for up to 50 blind or disabled people who would

otherwise require institutionalization. The cases states select are not subject to review by a Federal board like that established for Katie Beckett waivers. Under the model waivers, states can provide selected individuals a broader array of in-home services than the Medicaid program provides, can waiver deeming provisions, and can raise the income eligibility limit up to 300% of SSI. As of May 1984, eleven model waivers had been approved. These model waivers seemed to allow states to respond rapidly to the needs of specific individuals. Though model waivers can cover up to 50 persons, state requests often aim to meet the needs of one or two specific individuals for whom institutionalization can be avoided.

How could Medicaid further encourage family-provided care?

In addition to the waiver programs, two changes in Medicaid have been discussed as means to promote family care. One is the "carrot" of changing Medicaid policy to allow payments to family members for care of elderly kin. The other is the "stick", requiring adult children to pay a portion of the costs of nursing more care for elderly relatives. Figure 12 illustrates which states employ either or both of these approaches.

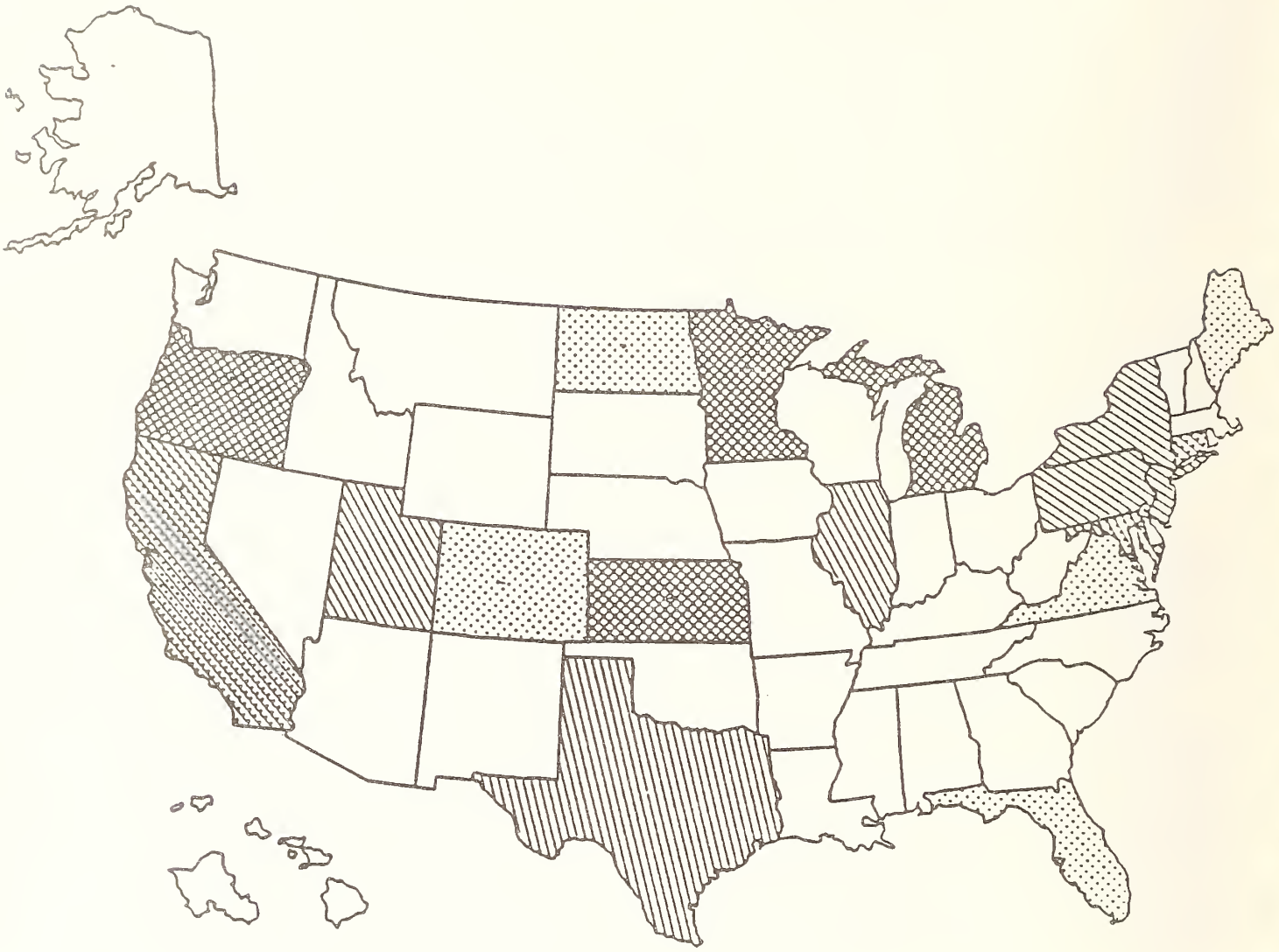
Paying family members. HCFA could propose to modify the definition of personal care services to permit reimbursement of family members. A new definition could also specify criteria for reimbursement of family members, such as permitting payments only in cases where the family is experiencing financial hardship or when the care provided by family members is determined essential to avoiding the recipient's placement in a nursing home.

Twelve state programs currently provide payments to relatives. One of these programs--Michigan's Adult Home Help Program--is, in fact, funded under Medicaid's personal care benefit. Michigan interprets that program's prohibition on payments to family members as applicable to family members who are legally responsible for the recipient's support (i.e., spouses and parents of children under 18 years of age). Few of these programs have been systematically evaluated. But some states' assessment of their experience provides some information on the advantages and disadvantages of paying family members. First, advantages:

- **Flexibility.** Cash payments to family members can add flexibility to the long-term care delivery system. States can pay family members when no other providers are available. For example, it is interesting that in several cases, payments to family members were initiated as a means to provide long-term care services to impaired elderly persons residing in rural areas, who have no access to agency providers. Second, cash payments provide flexibility for families to purchase services and supplies which are not provided through any other program, and can therefore serve a "gap-filling" function in the delivery of home-based services.

Figure 12

STATE FINANCIAL INCENTIVE PROGRAMS



= PAYMENTS TO FAMILY, MEDICAID

= PAYMENTS TO FAMILY, OTHER

= COLLECTION FROM FAMILY

= BOTH COLLECTION AND PAYMENT PROGRAMS

- **Higher quality care**. Many claim that family members provide better quality care than non-relative providers who have no emotional attachments to the carereceiver. There is also likely to be less turnover among family caregivers than among non-related providers.

- **Cost-effectiveness**. The cost of paying family members is generally lower than the cost of paying non-relative providers (on a per service basis) for two reasons: (1) family members will usually accept lower wages since they have other non-pecuniary motivations for providing care; and (2) non-relative providers, particularly those employed by an agency, have higher overhead costs. Consequently, it can be argued that the public gets a "better buy for its tax dollar" when paying family members.

- **Positive reinforcement**. The efforts of informal caregivers go largely unrewarded, and it is possible that paying family members even a nominal amount will communicate a message to family providers that the public values those efforts. This argument proposes that while the economic incentives of paying family members may not be great, the positive reinforcement of informal caregiving efforts with even a nominal financial remuneration could have a significant effect on relieving the caregiving burden.

On the other hand, some of the arguments against paying family members as care providers include:

- **Substitution effects**. This is by far the strongest argument against paying family members. The argument is that essentially the public is not "purchasing" any additional long-term care services by paying family providers, but simply spending public resources for services that would be provided in any case without an outlay in expenditures. Experience in Florida, Kansas, and Maryland indicate that paying relatives may indeed simply finance care that would otherwise be provided and may not reduce use of nursing homes.

- **Families may want services, not money**. Surveys of informal caregivers have generally found that given the option of financial payments or additional supportive services, most families indicate a desire for additional services. Financial payments to family caregivers may not significantly alter their caregiving behaviors to the point where institutionalization is avoided or delayed.

- **Equity problems.** In order for financial payments to family providers to be cost-effective, they would have to be targeted to family situations where caregiving efforts would increase, and where there are reasonable expectations for delaying or postponing nursing home placement, or utilization of other health care services paid by Medicaid. The targeting of financial payments to family members who meet specific criteria would inevitably mean that other families would not be eligible to receive payment for services provided. This could lead to claims of inequity, and perhaps the subsequent loosening of targeting criteria.

- **Care monitoring.** Some claim that the potential for abuse is greater when family members are paid providers, since there are no formal mechanisms for ensuring quality of care (licensing requirements, formal supervision, etc.). Care receivers may be more reluctant to report instances of abuse when a family member is the negligent provider. In any case, programs which pay family members as providers have had to establish new monitoring systems to ensure that abuse and neglect is not occurring.

- **Interference with the informal caregiving network.** There are those who state that the government should "leave well enough alone." This argument makes the case that the evidence is that the informal caregiving network is an extremely healthy one, and that public efforts to tinker with the network with financial incentives will do more harm than good. Paying family members for caring for their elderly kin may formalize the caregiving role, and alter normative values of family responsibility.

Further analysis will approach this policy option more analytically, and discuss in greater depth the positive and negative consequences of paying family caregivers as Medicaid providers.

Requiring financial contributions from adult children. An alternative to paying family members to provide care to the elderly is requiring family members to contribute resources when public programs provide that care. This policy option has received considerable attention since HCFA's 1983 issuance of a transmittal stating that states may require adult children to contribute to nursing home costs under state laws of general applicability. Prior to that transmittal, Medicaid law had been interpreted as prohibiting "deeming" of adult children's incomes. Some states did, however, allow families to voluntarily purchase additional "non-standard" services from nursing homes for related Medicaid recipients.

Although several states (including Indiana) considered enactment of family responsibility programs following HCFA's transmitted, only Idaho the state--actually adopted a program.

Under the provisions of Idaho's Family Responsibility Bill, the family responsibility requirement was treated as a third-party liability, and therefore has no effect on the eligibility determination process. Responsible relatives were identified at the time a nursing home applicant applies for Medicaid, or when an existing Medicaid client in a nursing home comes up for his/her annual eligibility redetermination. Responsible relatives were then mailed an explanation of their legal obligations under the Act, along with the assessment forms which were used to determine the relative's financial contribution. The amount of the assessment was determined by subtracting certain deductions from gross income (e.g., medical expenses, education expenses), further subtracting the poverty income level (by family size), and multiplying the balance by 4 percent.

Idaho's experience with its Family Responsibility program, though brief, is the only source of actual data which can be used to project outcomes of other programs which might be implemented in other states. The information is interesting in that it runs counter to some common assumptions. First, only 23 percent of the Medicaid recipients identified had no responsible relatives. This percentage is much lower than common estimates, at about 35-45 percent. However, the low proportion of Idaho Medicaid nursing home recipients without living relatives may not be representative of other states. Also, responsible relatives in the Idaho Family Responsibility program include spouses and parents of nursing home recipients, not just adult children.

The average number of responsible relatives per recipient was 2.05 and the average payment per responsible relative was $43.95 per month.

The delinquency rate in the program was very low, and of those payment delinquencies which did occur, most were on the part of out-of-state residents. Further, there were only ten appeals from assessed relatives, nine of which were granted. And finally, since the implementation of the Family Responsibility program was made part of the routine eligibility determination process, the state incurred no appreciable extra administrative costs. By the end of March 1984, the state had received total collections of $19,068.15.

However, on March 23, 1984, the Idaho State Attorney General rendered an opinion that brought the implementation of the Family Responsibility program to a halt. The Attorney General ruled that Idaho's program was not in conformity with Federal law, in that the program was not being implemented as part of a statute of general applicability, since it was only being applied to responsible relatives of nursing home recipients on Medicaid.

At present, there are no states which are requiring adult children of Medicaid nursing home recipients to contribute to the cost of care. Although current HCFA policy takes the position that family responsibility programs are a state option, the fact that states can only do so under a statute of general applicability appears to be a major impediment. While there appears to be political and executive support in states to require adult children of financial means to contribute to the cost of nursing home care for parents who are on Medicaid, states appear reluctant to enact and enforce legislation extending filial responsibility to persons who are not adult children of Medicaid nursing home recipients.

Whether, in fact, such laws would be fiscally worthwhile is open to question. Savings to government from a family responsibility program are a function of the income and assessment on family members, the collection rate and administrative cost. Surveys indicate that the family incomes of the closest living relative of Medicaid nursing home recipients are comparable to family incomes of private-pay recipients, suggesting that income is available to be tapped. However, contrary to popular belief, most states have proposed only a modest financial burden on adult children, and to require contributions only from those adult children in the upper income brackets.

An estimate made by HCFA's Division of Cost Estimates in November 1981 projected 1983 Federal savings of only $58 million from family responsibility, assuming that only 25 percent of adult children would make a contribution, and that administrative costs would amount to 70 percent of gross savings. Net savings from family responsibility programs are likely to offset only a small percentage of Medicaid nursing home costs unless states not only assess upper income families but also impose significant assessments on families of moderate incomes. For example, a Wisconsin study concluded that if the state hoped to save 5.7 percent of its Medicaid expenditures for nursing home care, it would have to assess every adult child with taxable income an average annual bill of nearly $800.

However, the real savings from family responsibility programs might not be derived from actual collections, but from their deterrent effect on nursing home placement. There is some claim (and some historical evidence from the Old Age Assistance Program), that if families knew that they would have to pay for a portion of nursing home costs, they might be less predisposed to placing their elderly parent in a nursing home.

Although Medicaid is the primary public supporter of nursing home care, it is not the only public policy affecting nursing home use or care in the home. Tax provisions that enhance elderly citizens' resources or offset caregivers expenses may also affect service use. What tax incentives* exist to help the elderly remain at home or obtain informal care?

- **Exclusion of Capital Gains on Home Sales for Individuals Age 55 and Over (Section 121 of the Tax Code).** This provision allows older taxpayers to avoid some or all of the tax liability that would accrue from price increases in the value of their homes. Without this exclusion, many taxpayers who become renters would be required to pay tax on approximately the difference between the sale price of their final home and the purchase price of their first. Information is not readily available to determine what would have been the financial impact on elderly couples without establishment of this provision.

---

*The Systemetrics report from which this chapter is taken provides an extensive primer on tax expenditure concepts, useful for analysis of this issue.

However, it is not difficult to surmise a situation where the independent living status of one or both elderly individuals could be jeopardized if this type of financial relief was not available.

- **Tax Credit for the Elderly (Section 37 of the Tax Code.** Another tax expenditure provision directed at a different segment of the retired or elderly population is the Tax Credit for the Elderly. Originally this provision was intended to remove inequities between individuals who receive retirement income that was not exempt and recipients of social security, which is exempt. In 1976, the Tax Credit for the Elderly was revised in order to update the income eligibility levels, simplify the credit calculation, and eliminate the discrimination among individuals depending on it as their source of income. Before this revision, elderly taxpayers who had to support themselves by earning income because they had no retirement income now could qualify for the credit--where they had previously been ineligible.

- **Additional Exemption for the Elderly (Section 151[c])** The Additional Tax Exemption for the Elderly was designed specifically to assist the elderly based solely on age without regard to the availability of retirement benefits or capital assets. Section 151(c) of the Tax Code allows an additional personal exemption of $1,000 for a taxpayer who is 65 or older.

- **Exemption for Dependents (Section 152 of the Tax Code)** The Dependent Exemption may also benefit taxpayers who care for chronically ill relatives if the elderly person meets the dependency and support tests. In addition to the dependent exemption, informal caregivers may also deduct the dependent's medical expenses following the general Federal tax criteria. However, because of the restrictive nature of the dependency and support tests, it is assumed that few taxpayers qualify and therefore this provision gives only limited assistance to a small segment of the total number of caregivers. It may very well be that the addition of the dependency test, particularly the limit to $1,000 unearned income for the dependent, leverages benefits to the low-income brackets much more than is fully appreciated.

- **Credit for Child and Dependent Care Expenses (Section 44A).** This provision is the major Federal tax expenditure that is of potential benefit to informal caregivers. A taxpayer who maintains a household is allowed a tax credit for employment-related expenses incurred for the care of a dependent child, a disabled

dependent, or a disabled spouse. The maximum credit is 30 percent of expenses up to $2,400 (for a maximum credit of $720) annually for one qualifying individual and up to $4,800 (for a maximum credit of $1,440) annually for two or more qualifying individuals, for taxpayers with adjusted gross income or $10,000 or less [CCH, 1984]. Because the credit rate phases down from 30 to 20 percent maximum as the income rises from $10,000 to $28,000, the credit targets greater benefit toward low- and middle-income taxpayers.

The child and dependent care tax credit was not originally designed strictly to assist in the care of children or the elderly. The intent of the provision was to allow a deduction of employment-related expenses comparable to an employee's business expenses (e.g., automobile, entertainment, meals and lodging while away on business overnight) in cases where taxpayers must incur such expenses. Between original enactment in 1954 and 1983 several relevant revisions have been made to this provision, which were designed to:

--encourage the hiring of domestic workers;

--encourage the care of incapacitated persons at home rather than in institutions;

--provide relief to middle-income taxpayers as well as low-income taxpayers; and

--provide relief for employment-related expenses or household services as well as for dependent care.

Four states (Idaho, Oregon, Arizona, and Iowa) recently adopted tax programs similar to the Federal exemption and credit, targeted to the elderly or their caregivers. These programs, which range in their structure and scope, have not yet been evaluated. Iowa's program, which allows a tax deduction of up to $5,000 for expenses incurred by an informal caregiver, appears to be the most extensive program of this type. It went into effect in 1983.

The states that currently operate tax expenditure programs provide an excellent opportunity to examine the issue of targeting. The questions that emerge are: Is it better to begin a tax expenditure program that is targeted very narrowly, examine the results, and then decide to expand the target population? Or, is it better to start a tax program that is generally available to the elderly population, without reference to disabilities necessitating additional support or financial relief? What are the cost impacts of beginning a narrow or broadly defined tax expenditure program, given a certain population composition? How does the availability of community-based services, such as home health care, affect the success of the

broadly targeted tax expenditure program? What measures should be used to examine whether the benefit gained from the tax relief is equal to the invested expenditure? Can targeted tax expenditure programs at least partially facilitate a reduction in the use of institutional services for the elderly? A state must make its tax expenditure policy decisions with these questions in mind.

MEDICAID PROGRAM EVALUATION WORKING PAPERS

Contractor	Working Paper Number
ABT ASSOCIATES, INC.	
1. Koetting, M. and Olinger, L. Selective Contracting in California: The First Year. November 1984.	3.1
2. Cromwell, J. and Hurdle, S. National Impact Study of Alternative Reimbursement Waivers. December 1984.	3.2
3. Korda, H. and Koetting, M. State Medicaid Inpatient Hospital Reimbursement. December 1984.	3.3
JAMES BELL AND ASSOCIATES	
4. Beyna, John and Trutko, John. Exploring the Effect of PPS on Medicaid, October 1984.	8.1
5. Bell, J. and Rosenthal, H. Primary Care Case Management -- A Case Study of the Michigan Program. Preliminary draft January 1985.	4.2
SYRACUSE UNIVERSITY	
6. Long, S. and Settle, R. The Impact of Eligibility Changes Under the Omnibus Budget Reconciliation Act of 1981 on the Characteristics of the Medicaid Population. November 1984.	5.3
7. Long, S. and Settle, R. Cutbacks in Medicaid Eligibility Under the OBRA of 1981: Implications for Access to Health Care Among the Newly Ineligible. January 1985.	5.4
8. Burkhead, J., Davitt, P., and Walker, P. Case Study of Post-OBRA Budgeting in New York. Preliminary draft February 1985.	7.4
9. Long, S. and Settle, R. Federal Financial Participation in Medicaid: A Conceptual Evaluation. Preliminary draft February 1985.	7.5

NATIONAL GOVERNORS' ASSOCIATION

10. Bartlett, et al. A Descriptive Analysis of State Responses to the Provisions of Section 2175 of OBRA. Preliminary review draft February 1985. 4.1

11. Hill, I. Medicaid Eligibility: A Descriptive Report of OBRA, TEFRA, and DEFRA Provisions, and State Responses. October 1984. 5.2

URBAN INSTITUTE

12. Cohen, J. and Holahan, J. Medicaid Eligibility After the Omnibus Budget Reconciliation Act of 1981. #3339-01. October 1985. 5.1

13. Cohen, J. Success and Failure in Containing Medicaid Costs: Twelve States' Experience Between 1981 and 1982. #3339-02. October 1985. 7.1

14. Davis, W. and Gullo, T. State Budget Priorities and Medicaid. #3339-04. October 1984. 7.2

15. Holahan, J. The Effects of the 1981 Omnibus Budget Reconciliation Act on Medicaid. #3339-03. November 1984. 7.3

16. Feder, J. and Holahan, J., eds. Medicaid Program Evaluation: A Synthesis of Interim Findings. June 1986. 9.1

LA JOLLA MANAGEMENT CORPORATION

17. Steinhardt, B., Burwell, B. and Brudevold, C. Studies Evaluating Medicaid Home and Community Based Waivers. January 1985. 1.1

SYSTEMETRICS

18. Burwell, B. and Brudevold, C. Financial Incentives for Family Care. June 1984. 2.1

CMS LIBRARY
3 8095 00013289 0